Filing Company: ProAssurance Wisconsin Insurance Company State Tracking Number: PCWA-127383456

Company Tracking Number: IL-DPL-012012-RR

TOI: 11.0 Medical Malpractice - Claims Sub-TOI: 11.0007 Dentists - Oral Surgeons

Made/Occurrence

Product Name: Health Care Professional Liability Rates and Rules Manual

Project Name/Number: Rate/Rule Filing and New PRA Format/

# Filing at a Glance

Company: ProAssurance Wisconsin Insurance Company

Product Name: Health Care Professional SERFF Tr Num: PCWA-127383456 State: Illinois

Liability Rates and Rules Manual

TOI: 11.0 Medical Malpractice - Claims SERFF Status: Closed-Filed State Tr Num: PCWA-127383456

Made/Occurrence

Sub-TOI: 11.0007 Dentists - Oral Surgeons Co Tr Num: IL-DPL-012012-RR State Status:

Filing Type: Rate/Rule Reviewer(s): Gayle Neuman

Author: LaQuita Goodwin Disposition Date: 01/05/2012

Date Submitted: 08/24/2011 Disposition Status: Filed

Effective Date Requested (New): 01/01/2012 Effective Date (New): 01/01/2012

01/01/2012

State Filing Description:

\*\*\*\*\*\* FILING ROUTED 11/1/11 \*\*\*\*\*\*\*\*

# **General Information**

Project Name: Rate/Rule Filing and New PRA Format

Status of Filing in Domicile: Not Filed
Project Number:

Domicile Status Comments: None

Reference Organization: None Reference Number:
Reference Title: Advisory Org. Circular:

Filing Status Changed: 01/05/2012

State Status Changed: Deemer Date:

Created By: LaQuita Goodwin Submitted By: LaQuita Goodwin

Corresponding Filing Tracking Number:

Filing Description:

I submit for your review and approval the rate and rule filing for the Health Care Professional Liability Program. I request the effective date of January 1, 2012, for this filing submission.

The attached manual's format, which replaces the former PIC Wisconsin Healthcare Providers Professional Liability manual's format, has been revised to be more in line of what we're doing in Illinois under the ProAssurance Casualty Company's physician and surgeon program, as well as other states. The specialty codes and class plan have changed and, due to the new format, will no longer contain rating factors, but the actual rate tables instead.

Filing Company: ProAssurance Wisconsin Insurance Company State Tracking Number: PCWA-127383456

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TOI: 11.0 Medical Malpractice - Claims Sub-TOI: 11.0007 Dentists - Oral Surgeons

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The Filing Memorandum and its exhibits should explain how the rates were developed, which is an overall 17.5% rate impact. Some rules that weren't being used were deleted and other coverages were enhanced. Due to the complex formatting issues, I'm unable to provide a marked copy of the manual changes.

If you have any questions during the review process, please let me know.

Thank you.

# **Company and Contact**

# **Filing Contact Information**

 100 Brookwood Place
 205-877-4426 [Phone]

 Birmingham, AL 35209
 205-414-2887 [FAX]

**Filing Company Information** 

ProAssurance Wisconsin Insurance Company CoCode: 23400 State of Domicile: Wisconsin 100 Brookwood Place Group Code: 2698 Company Type: Property &

Casualty

Birmingham, AL 35209 Group Name: ProAssurance Group State ID Number: 12

(205) 877-4426 ext. [Phone] FEIN Number: 39-1567580

-----

# **Filing Fees**

Fee Required? No Retaliatory? No

Fee Explanation:

Per Company: No

COMPANY AMOUNT DATE PROCESSED TRANSACTION #

ProAssurance Wisconsin Insurance Company \$0.00

# **State Specific**

Refer to our checklists prior to submitting filing

Filing Company: ProAssurance Wisconsin Insurance Company State Tracking Number: PCWA-127383456

Company Tracking Number: IL-DPL-012012-RR

TOI: 11.0 Medical Malpractice - Claims Sub-TOI: 11.0007 Dentists - Oral Surgeons

Made/Occurrence

Product Name: Health Care Professional Liability Rates and Rules Manual

Project Name/Number: Rate/Rule Filing and New PRA Format/

(http://www.idfpr.com/DOI/Prop\_Cas\_IS3\_Checklists/IS3\_Checklists.htm).: Acknowledged

Refer to our updated (04/06/2007) SERFF General Instructions prior to submitting filing. They have been updated to clarify what rates and rules are required to be filed as well as what rates and rules are not required to be filed. Also, the "Product Name" is the Filing Title and not the Project Number.: Acknowledged

NO RATES and/or RULES ARE REQUIRED TO BE FILED FOR LINES OF COVERAGE SUCH AS COMMERCIAL AUTO (except taxicabs), BURGLARY AND THEFT, GLASS, FIDELITY, SURETY, COMMERCIAL GENERAL LIABLITY, CROP HAIL, COMMERCIAL PROPERTY, DIRECTORS AND OFFICERS, ERRORS AND OMMISSIONS, COMMERCIAL MULTI PERIL just to mention a few. However, a Summary Sheet (RF-3) is required to be filed. Please refer to the State Specific Field below for what rates/rules are required to be filed and to our checklists for specific statutes, regulations, etc.: http://www.idfpr.com/DOI/Prop\_Cas\_IS3\_Checklists/IS3\_Checklists.htm: N/A Medical Malpractice rates/rules may only be submitted in paper.: According to Gayle Neuman, med mal rates/rules can now be submitted in SERFF

The only rates and/or rules that are required to be filed are Homeowners, Mobile Homeowners, Dwelling Fire and Allied Lines, Workers' Compensation, Liquor Liability, Private Passenger Automobiles, Taxicabs, Motorcycles and Group Inland Marine Insurance which only applies to insurance involving personal property owned by, being purchased by or pledged as collateral by individuals, and not used in any business, trade or profession per Regulation Part 2302 which says in part, "each company shall file with the Director of Insurance each rate, rule and minimum premium before it is used in the State of Illinois.": N/A

When selecting a form filing type for a multiple form filing, use the dominant type from these choices: APP - application; CER - certificate; COF - coverage form; DPS - declaration page; END - endorsement; POJ - policy jacket; ORG - Companies adopting an Advisory or Rating Organization's filing. Example: If you are submitting a policy as well as endorsements, a declaration page and an application, you would select "POL" for policy.: N/A

PCWA-127383456 SERFF Tracking Number: State: Illinois

Filing Company: ProAssurance Wisconsin Insurance Company State Tracking Number: PCWA-127383456

Company Tracking Number: IL-DPL-012012-RR

TOI: 11.0 Medical Malpractice - Claims Sub-TOI: 11.0007 Dentists - Oral Surgeons

Made/Occurrence

Product Name: Health Care Professional Liability Rates and Rules Manual

Project Name/Number: Rate/Rule Filing and New PRA Format/

# **Correspondence Summary**

# **Dispositions**

**Status Created By Created On Date Submitted** 

Filed Gayle Neuman 01/05/2012 01/05/2012

**Objection Letters and Response Letters** 

**Objection Letters Response Letters Status** Created By Created On Date Submitted **Responded By Created On** 

**Date Submitted** 

LaQuita Goodwin 10/27/2011 Gayle Neuman 10/20/2011 Pending 10/20/2011 10/27/2011

Industry Response

Gayle Neuman 09/20/2011 LaQuita Goodwin 09/26/2011 Pending 09/20/2011 09/26/2011

Industry Response

**Amendments** 

#### **Schedule Schedule Item Name Created By Date Submitted** Created On

Revised Manual Page Rate LaQuita Goodwin 11/04/2011 11/04/2011 PRA Wis 11/3/2011 letter to Pinnacle Supporting LaQuita Goodwin 11/04/2011 11/04/2011

Document

**Filing Notes** 

Subject Created By **Date Submitted** Note Type Created

On

**Effective Date** Note To Reviewer LaQuita Goodwin 01/05/2012 01/05/2012

effective date Note To Filer Gayle Neuman 01/05/2012 01/05/2012

Filing Company: ProAssurance Wisconsin Insurance Company State Tracking Number: PCWA-127383456

Company Tracking Number: IL-DPL-012012-RR

TOI: 11.0 Medical Malpractice - Claims Sub-TOI: 11.0007 Dentists - Oral Surgeons

Made/Occurrence

Product Name: Health Care Professional Liability Rates and Rules Manual

Project Name/Number: Rate/Rule Filing and New PRA Format/

Filing Company: ProAssurance Wisconsin Insurance Company State Tracking Number: PCWA-127383456

Company Tracking Number: IL-DPL-012012-RR

TOI: 11.0 Medical Malpractice - Claims Made/Occurrence Sub-TOI: 11.0007 Dentists - Oral Surgeons

Product Name: Health Care Professional Liability Rates and Rules Manual

Project Name/Number: Rate/Rule Filing and New PRA Format/

# **Disposition**

Disposition Date: 01/05/2012

Effective Date (New): 01/01/2012

Effective Date (Renewal): 01/01/2012

Status: Filed Comment:

Company Name:	Overall %	Overall % Rate	Written	# of Policy	Written	Maximum %	Minimum %
	Indicated	Impact:	Premium	Holders	Premium for	Change (where	Change (where
	Change:		Change for	Affected for this	this Program:	required):	required):
			this	Program:			
			Program:				
ProAssurance Wisconsin Insurance Company	107.300%	17.500%	\$183,796	720	\$1,008,719	98.020%	-2.680%

Filing Company: ProAssurance Wisconsin Insurance Company State Tracking Number: PCWA-127383456

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TOI: 11.0 Medical Malpractice - Claims Sub-TOI: 11.0007 Dentists - Oral Surgeons

Made/Occurrence

Product Name: Health Care Professional Liability Rates and Rules Manual

Project Name/Number: Rate/Rule Filing and New PRA Format/

Schedule	Schedule Item	Schedule Item Status	<b>Public Access</b>
Supporting Document	Explanatory Memorandum		Yes
Supporting Document	Form RF3 - (Summary Sheet)		Yes
Supporting Document	Certification		Yes
Supporting Document	Manual		Yes
Supporting Document	Response to 9/20/2011 objections		Yes
Supporting Document	PRA Wis 11/3/2011 letter to Pinnacle		Yes
Rate (revised)	Underwriting Manual		Yes
Rate	Underwriting Manual		Yes
Rate	Revised Manual Page		Yes

Filing Company: ProAssurance Wisconsin Insurance Company State Tracking Number: PCWA-127383456

Company Tracking Number: IL-DPL-012012-RR

TOI: 11.0 Medical Malpractice - Claims Sub-TOI: 11.0007 Dentists - Oral Surgeons

Made/Occurrence

Product Name: Health Care Professional Liability Rates and Rules Manual

Project Name/Number: Rate/Rule Filing and New PRA Format/

# **Objection Letter**

Objection Letter Status Pending Industry Response

Objection Letter Date 10/20/2011 Submitted Date 10/20/2011 Respond By Date 10/31/2011

Dear LaQuita Goodwin,

This is to acknowledge receipt of your filing. Your submission is not acceptable for filing in Illinois due to the following reasons:

- 1. Under I. Rates and Premium Calculations, paragraph B. Please confirm that no insureds are currently written on an individual risk basis and that prior to issuing any such coverage such standards would be filed with the Department prior to implementation.
- 2. Under I. Rates and Premium Calculations, paragraph C. Illinois does not allow insureds to be written on a consent-to-rate basis. This issue is again referenced under IX. Reporting Endorsement Premium Calculation.
- 3. Under Part-Time and Semi-Retired Professionals, the manual indicates dentists working less than 12 hours a week will be individually evaluated by the company. Do you have a set discount for the "less than 12 hours weekly" group? We require a written statement certifying that the insurance company does not unfairly discriminate in offering or administering this program.
- 4. Under Locum Tenens, explain why a processing/administrative costs would be waived for certain applicants by the underwriters.
- 5. Based on the calculations for other debits and credits in this manual, why can't the company provide perimeters (such as classes, patient visits, etc.) for the Full-Time Equivalent Rating?
- 6. Please explain all other basis for the waiver of the Reporting Endorsement Premium beyond those in the coverage form/policy. Additionally, please confirm the extended reporting period (tail) coverage premium is priced as a factor of one of the following: (1) the last twelve months premium; (2) the premium in effect at policy issuance; or (3) the expiring annual premium.
- 7. Explain why the 25% maximum credit should not apply to risks developing over \$100,000 in premium annually. Does this take into consideration their policy limits?

Filing Company: ProAssurance Wisconsin Insurance Company State Tracking Number: PCWA-127383456

Company Tracking Number: IL-DPL-012012-RR

TOI: 11.0 Medical Malpractice - Claims Sub-TOI: 11.0007 Dentists - Oral Surgeons

Made/Occurrence

Product Name: Health Care Professional Liability Rates and Rules Manual

Project Name/Number: Rate/Rule Filing and New PRA Format/

- 8. Please provide the percentage to be charged for the Partnership-Corporation-Professional Association Extended Reporting Period endorsement. Please confirm the extended reporting period (tail) coverage premium is priced as a factor of one of the following: (1) the last twelve months premium; (2) the premium in effect at policy issuance; or (3) the expiring annual premium.
- 9. Under Allied Health Professional Employees (on page 21), please confirm the extended reporting period (tail) coverage premium is priced as a factor of one of the following: (1) the last twelve months premium; (2) the premium in effect at policy issuance; or (3) the expiring annual premium.
- 10. The Reporting Endorsement Rates by Year (on page 30 and 31) should clarify these rates only apply to individuals.
- 11. Under II. Exceptions (on page 34) sentence 2, the word "Law" should be replaced with "Amendatory".
- 12. On page 17, there is a Claims Free Credit Program (under the section titled "Additional Practice Charges"?). On page 36, a Loss Free Discount is being added, in addition to a Loss Free Discount Program. Based on review of this information, is the 10 year evaluation period being replaced and the insured gets a discount at 4 years claims free?
- 13. On 9/26/11, you provided a summary of proposed changes. Please explain where "16. Vicarious liability charge is changing from 10% to 30%" is addressed in the manual.

Additionally, the extended reporting period coverage offered at no additional charged (described under #19) was not included in the filing.

Sign up to get e-mail notification for updates to the Department's website. http://insurance.illinois.gov/RSS/

Please refer to the appropriate Property Casualty IS3 Review Requirements Checklist before submitting any filing. The checklists are available at the Department's Web site or at the following link:

http://insurance.illinois.gov/Prop\_Cas\_IS3\_Checklists/IS3\_Checklists.htm

Please submit compliant form(s) no later than the date shown above or the entire filing may be disapproved. Please be advised that when the Director disapproves the form(s) you must immediately cease using the form(s) in Illinois.

Please give this matter your immediate attention. If you have any question regarding this filing please feel free to contact me.

Filing Company: ProAssurance Wisconsin Insurance Company State Tracking Number: PCWA-127383456

Company Tracking Number: IL-DPL-012012-RR

TOI: 11.0 Medical Malpractice - Claims Sub-TOI: 11.0007 Dentists - Oral Surgeons

Made/Occurrence

Product Name: Health Care Professional Liability Rates and Rules Manual

Project Name/Number: Rate/Rule Filing and New PRA Format/

Sincerely,

Gayle Neuman

Filing Company: ProAssurance Wisconsin Insurance Company State Tracking Number: PCWA-127383456

Company Tracking Number: IL-DPL-012012-RR

TOI: 11.0 Medical Malpractice - Claims Sub-TOI: 11.0007 Dentists - Oral Surgeons

Made/Occurrence

Product Name: Health Care Professional Liability Rates and Rules Manual

Project Name/Number: Rate/Rule Filing and New PRA Format/

# **Response Letter**

Response Letter Status Submitted to State

Response Letter Date 10/27/2011 Submitted Date 10/27/2011

Dear Gayle Neuman,

#### Comments:

The responses to your 10/20/2011 objections follows below.

# Response 1

Comments: 1. I have confirmed that no insureds are currently written on a individual risk basis. Also, prior to issuing such coverage, we are aware that it should be filed with the Department prior to implementation.

- 2. I have deleted paragraph C regarding consent to rates. Please refer to page 4.
- 3. I have deleted the language in question under the part-time and semi-retired professionals provision on page 6.
- 4. Based on the wording in our new policy effective 2/1/2012, insureds can have locum tenens coverage up to 45 days without prior company approval, I have removed the reference to the administrative cost on page 6.
- 5. Please see the revised rule on page 7, which defines the parameters for the calculation of FTE.
- 6. Other than the waiver of the reporting endorsement premium contained in the policy, there are no other basis for waiving the premium. I have amended Item B on Page 9.
- 7. I have deleted the language in question under the maximum credit provision on page 11.
- 8. The rule on page 16 states that the tail premium will be a percentage of the sum of each member dentist's net individual reporting endorsement premium, based on the number of insureds and the corp table. Also, we confirm the tail coverage premiums is priced at the premium in effect at policy issuance and this language is in our policy.
- 9. For allied health professional employees, we confirm the tail coverage premiums is priced at the premium in effect at policy issuance and this language is in our policy.
- 10. Please note that the claims-made rates, reporting endorsement rates and occurrence rates in Section 7, located on

Filing Company: ProAssurance Wisconsin Insurance Company State Tracking Number: PCWA-127383456

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Made/Occurrence

Product Name: Health Care Professional Liability Rates and Rules Manual

Project Name/Number: Rate/Rule Filing and New PRA Format/

pages 28 to 32, only apply to individual dentists.

- 11. I have replaced the word "Law" with the word "Amendatory" on page 34.
- 12. Please note that the Loss Free Discount on page 36 is replacing the Claims Free Credit Program located on page 17.
- 13. Prior to this filing, we offered a 10% vicarious liability charge. I have amended page 16 of the manual to state that for each member dentist not individually insured by the Company, a premium charge for vicarious liability will be made equal to 30% of the appropriate rate, etc.
- 14. The extended reporting period coverage, which is offered at no additional charge, is located in the 1/1/2012 forms filing under SERFF Number PCWA-127627828.

# **Changed Items:**

No Supporting Documents changed.

No Form Schedule items changed.

#### Rate/Rule Schedule Item Changes

Exhibit Name	Rule # or Page #	Rate Action	Previous State Filing #
Underwriting Manual	Entire Manual, Pages 1 to 38	Replacement	IL-DPL-0208
Previous Version			
Underwriting Manual	Entire Manual, Pages 1 to 38	Replacement	IL-DPL-0208
If you have any additional gu	estions or concerns, please let	me know	

Thank you.

Sincerely,

LaQuita Goodwin

Filing Company: ProAssurance Wisconsin Insurance Company State Tracking Number: PCWA-127383456

Company Tracking Number: IL-DPL-012012-RR

TOI: 11.0 Medical Malpractice - Claims Sub-TOI: 11.0007 Dentists - Oral Surgeons

Made/Occurrence

Product Name: Health Care Professional Liability Rates and Rules Manual

Project Name/Number: Rate/Rule Filing and New PRA Format/

# **Objection Letter**

Objection Letter Status Pending Industry Response

Objection Letter Date 09/20/2011
Submitted Date 09/20/2011
Respond By Date 09/27/2011

Dear LaQuita Goodwin,

This is to acknowledge receipt of your filing. Your submission is not acceptable for filing in Illinois due to the following reasons:

Please indicate if your company has a plan for the gathering of statistics or the reporting of statistics to statistical agencies? If yes, what stat agency is being used?

Pursuant to 50 III. Adm. Code 754.10, identification of all changes in all superseding filings, as well as identification of all superseded filings is required. Additionally, we require you certify that nothing else has changed from what was previously filed except for the changes brought to our attention in this filing.

Sign up to get e-mail notification for updates to the Department's website. http://insurance.illinois.gov/RSS/

Please refer to the appropriate Property Casualty IS3 Review Requirements Checklist before submitting any filing. The checklists are available at the Department's Web site or at the following link:

http://insurance.illinois.gov/Prop\_Cas\_IS3\_Checklists/IS3\_Checklists.htm

Please submit compliant form(s) no later than the date shown above or the entire filing may be disapproved. Please be advised that when the Director disapproves the form(s) you must immediately cease using the form(s) in Illinois.

Please give this matter your immediate attention. If you have any question regarding this filing please feel free to contact me.

Sincerely,

Gayle Neuman

Filing Company: ProAssurance Wisconsin Insurance Company State Tracking Number: PCWA-127383456

Company Tracking Number: IL-DPL-012012-RR

TOI: 11.0 Medical Malpractice - Claims Sub-TOI: 11.0007 Dentists - Oral Surgeons

Made/Occurrence

Product Name: Health Care Professional Liability Rates and Rules Manual

Project Name/Number: Rate/Rule Filing and New PRA Format/

# **Response Letter**

Response Letter Status Submitted to State

Response Letter Date 09/26/2011 Submitted Date 09/26/2011

Dear Gayle Neuman,

#### **Comments:**

Please find following the response to your 9/20/2011 objection below.

# Response 1

Comments: Please refer to the attached document for our responses.

#### **Changed Items:**

#### **Supporting Document Schedule Item Changes**

Satisfied -Name: Response to 9/20/2011 objections

Comment:

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

If you have any other questions or concerns, please let me know.

Thank you.

Sincerely,

LaQuita Goodwin

Filing Company: ProAssurance Wisconsin Insurance Company State Tracking Number: PCWA-127383456

Company Tracking Number: IL-DPL-012012-RR

TOI: 11.0 Medical Malpractice - Claims Sub-TOI: 11.0007 Dentists - Oral Surgeons

Made/Occurrence

Product Name: Health Care Professional Liability Rates and Rules Manual

Project Name/Number: Rate/Rule Filing and New PRA Format/

**Note To Reviewer** 

Created By:

LaQuita Goodwin on 01/05/2012 10:23 AM

**Last Edited By:**Gayle Neuman

**Submitted On:** 

01/05/2012 01:59 PM

Subject:

**Effective Date** 

#### Comments:

I filed for ProAssurance Wisconsin without realizing the merger was going to be effective 12/31/2012. Yes, the filing was put into effect on January 1, 2012 and we would like to keep this same date. You instructed me to file for ProAssurance Casualty as well, and this is currently pending under SERFF Filing Number PCWA-127935301.

Thank you for your assistance in this matter.

Filing Company: ProAssurance Wisconsin Insurance Company State Tracking Number: PCWA-127383456

Company Tracking Number: IL-DPL-012012-RR

TOI: 11.0 Medical Malpractice - Claims Sub-TOI: 11.0007 Dentists - Oral Surgeons

Made/Occurrence

Product Name: Health Care Professional Liability Rates and Rules Manual

Project Name/Number: Rate/Rule Filing and New PRA Format/

**Note To Filer** 

Created By:

Gayle Neuman on 01/05/2012 09:22 AM

Last Edited By: Gayle Neuman Submitted On:

01/05/2012 01:59 PM

Subject:

effective date

#### Comments:

The Department of Insurance has now completed its review of the filing referenced above. Originally, ProAssurance Wisconsin requested the filing be effective January 1, 2012. Was the filing put in effect on January 1, 2012 or do you wish to have a different effective date? I thought you were wanting to change the company's name by that date? Your prompt response is appreciated.

Filing Company: ProAssurance Wisconsin Insurance Company State Tracking Number: PCWA-127383456

Company Tracking Number: IL-DPL-012012-RR

TOI: 11.0 Medical Malpractice - Claims Sub-TOI: 11.0007 Dentists - Oral Surgeons

Made/Occurrence

Product Name: Health Care Professional Liability Rates and Rules Manual

Project Name/Number: Rate/Rule Filing and New PRA Format/

**Amendment Letter** 

Submitted Date: 11/04/2011

**Comments:** 

Pursuant to your request, I have attached the 11/3/2011 response to Pinnacle.

**Changed Items:** 

Rate/Rule Schedule Item Changes:

Exhibit Name: Rule # or Rate Previous State Attach

Page #: Action: Filing Number: Document:

Revised Manual Page 12 Replacement Previous State Filing Num: IL-DPL- Revised page 12.PDF

Page 0208

**Supporting Document Schedule Item Changes:** 

User Added -Name: PRA Wis 11/3/2011 letter to Pinnacle

Comment:

PRA Wis 11-3-11 letter to Pinnacle.PDF

Filing Company: ProAssurance Wisconsin Insurance Company State Tracking Number: PCWA-127383456

Company Tracking Number: IL-DPL-012012-RR

TOI: 11.0 Medical Malpractice - Claims Made/Occurrence Sub-TOI: 11.0007 Dentists - Oral Surgeons

Product Name: Health Care Professional Liability Rates and Rules Manual

Project Name/Number: Rate/Rule Filing and New PRA Format/

# **Rate Information**

Rate data applies to filing.

Filing Method: File and Use

Rate Change Type: Increase

Overall Percentage of Last Rate Revision: -0.200%

Effective Date of Last Rate Revision: 02/15/2008

Filing Method of Last Filing: File and Use

**Company Rate Information** 

Company Name:	Overall %	Overall % Rate	Written	# of Policy	Written	Maximum %	Minimum %
	Indicated	Impact:	Premium	Holders	Premium for	Change (where	Change (where
	Change:		Change for	Affected for this	this Program:	required):	required):
			this Program:	Program:			

Insurance Company

Filing Company: ProAssurance Wisconsin Insurance Company State Tracking Number: PCWA-127383456

Company Tracking Number: IL-DPL-012012-RR

TOI: 11.0 Medical Malpractice - Claims Sub-TOI: 11.0007 Dentists - Oral Surgeons

Made/Occurrence

Product Name: Health Care Professional Liability Rates and Rules Manual

Project Name/Number: Rate/Rule Filing and New PRA Format/

# Rate/Rule Schedule

Schedule Item Exhibit Name: Rule # or Page Rate Action Previous State Filing Attachments
Status: #: Number:

Underwriting Manual Entire Manual, Replacement IL-DPL-0208 Illinois Dental Manual

Pages 1 to 38 eff 1-1-12.PDF

Revised Manual Page Page 12 Replacement IL-DPL-0208 Revised page 12.PDF



# PROASSURANCE WISCONSIN INSURANCE COMPANY HEALTH CARE PROFESSIONALS UNDERWRITING RULES AND RATES

# **ILLINOIS MANUAL**

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# **SECTION 1**

**INTRODUCTION** 

#### INTRODUCTION

This manual contains the classifications and rates governing the underwriting of Dentists and Allied Health Professionals' Professional Liability Insurance by ProAssurance Wisconsin Insurance Company, hereinafter referred to as "the Company."

#### I. RATES AND PREMIUM CALCULATIONS

- Rates apply on a per incident and annual aggregate basis. The rates for the premium classifications selected by the Company or any special situations not delineated herein are those described in the Professional Liability State Rates and Exceptions Section of this manual, with a minimum premium being \$500 (\$250 first and second-year claims-made coverage and for Allied Health Professionals). If an individual's practice involves two or more rating territories or rating classifications, the highest rating territory or classification applies. Endorsements adding risks/exposures mid-term will be rated in accordance with the Rates and Rules in effect as of the endorsement effective date. Subject to Section 2., V, (Rate Adjustments for Changes in Exposure) of this manual, Reporting Endorsements will be rated in accordance with the Rates and Rules in effect as of the endorsement effective date. Subject to Section 2, V, (Rate Adjustments for Changes in Exposure) of this manual, endorsements effecting changes on risks/exposures currently insured will be rated using the Rules (e.g., rating classification, limits of liability and rating territory) in effect on the date of the change combined with the rates in effect on the later date of either i) the policy term effective date or ii) risk effective date.
- B. Refer to the Company for: Agents should refer to the Company any risk meeting one of the following criteria: a) Any risk or exposure for which there is no manual rate or applicable classification, or b) Risks developing annualized premium of \$100,000 or more for basic limits for individual (a) rating.
- C. Whole Dollar Premium Rule: The premiums appearing in the State Rates and Exceptions Section of this manual have been rounded to the nearest whole dollar. This procedure shall also apply to all interim premium adjustments, including endorsements or cancellations. A premium involving \$.50 or over, shall be rounded to the next higher whole dollar.

#### II. CANCELLATIONS

Cancellations shall be made only within the parameters established by the State of policy issuance as framed in the Cancellation provisions of the policy including any State-specific endorsement thereto.

- A. By the Company: The earned premium shall be determined on a "pro rata" basis.
- B. By the Insured: The earned premium may be determined on a "short rate" basis if the entire policy is cancelled. Pro-rata calculation shall be used if a portion of the coverages or risks are cancelled but other portions of the policy remains in force. "Short rate" calculation means that total earned premium shall equal actual earned premium as of the date of cancellation plus a short rate penalty equal to ten percent (10%) of unearned premium for the remainder of the policy period.
- C. <u>Removal from the State</u>: Subject to state provisions, the policy may be canceled by the Company after the insured no longer maintains at least 75% of his dental practice within the state of issuance, subject to proper notice.

# **SECTION 2**

CLASSIFICATION AND/OR RATING MODIFICATIONS AND PROCEDURES

# **CLASSIFICATION AND/OR RATING MODIFICATIONS AND PROCEDURES**

# I. PART-TIME AND SEMI-RETIRED PROFESSIONALS

The Part-Time Discount is available to dentists:

- A. who have at least 15 years of postgraduate clinical practice experience and are scaling back their practice in anticipation of retirement; or
- B. who practice less than 20 hours per week due to family needs (caring for young children and/or ill or disabled family members); or
- C. who are required to practice on a reduced basis as a result of a physical or medical condition, with the company's approval; or
- D. who practice at least 30 hours per week at a hospital, community health center or other health care facility where medical professional liability insurance is provided by the facility. A certificate of insurance listing the Company as certificate holder must be presented annually for the credit to apply.

Insureds eligible for the New Dentist Discount are not eligible for the Part-Time Discount. Also, dentists employing or supervising paramedicals (as listed in Section V, Item I) are not eligible for the Part-Time Discount.

This discount is intended to more accurately rate the insured who practices his specialty on a limited basis. The available discounts are:

		Average Weekly Practice
<b>TYPE</b>	<u>Class</u>	<b>Hours &lt; 20 hours</b>
Dentist	1A to 5	50%
All other		None

Practice hours are defined as:

- hospital rounds,
- charting and patient planning,
- on call hours involving patient contact, whether direct or by telephone,
- consultation with other dentists, and
- patient visits/consultations.

Practice hours of dentists receiving the Part-Time Discount are subject to random audit by the Company.

#### II. LOCUM TENENS

Coverage for temporary substitute health care providers may be provided through the issuance of an Additional Insured endorsement or the Locum Tenens Endorsement. In states not requiring a separate set of limits for the substitute, the Locum Tenens health care providers will be added to the insured's policy as an additional insured, sharing in the insured health care provider's limits. In states requiring separate limits for each health care provider, a Locum Tenens endorsement will be added to the insured health care provider's policy, providing a separate set of temporary limits to the Locum Tenens. Locum tenens coverage should not exceed a period of 90 days.

The locum tenens dentist must submit an application for Company approval in advance of the requested effective date of coverage.

#### III. CORPORATE LIABILITY - SHARED LIMIT

Where allowed by law, no charge will be made for entities sharing in the available limits of liability of the insured dentists or other insured organizations, providing each member is insured by the Company and the risk is otherwise acceptable.

# IV. FULL-TIME EQUIVALENT RATING

Rating of certain multi-dentist groups may, at the Company's option, be determined on a full-time equivalent (FTE) unit basis. Under this rating method, policies may be issued to positions with individuals who may fill such positions identified rather than being issued to specific individuals. An FTE rate will be determined based upon the filed and approved rate for a given classification of dentists but will be allocated based upon either the number of average hours of practice for a given specialty (2,080 hours of work per FTE) or the average number of patient contacts/visits in a 12 month period (4,000 visits per FTE). A risk with fewer than 50,000 encounters each year will not qualify for full-time equivalent rating.

All FTE rated applications shall be referred to the Company.

# V. RATE ADJUSTMENTS FOR CHANGES IN EXPOSURE -- CLAIMS-MADE, RETROACTIVE, AND REPORTING ENDORSEMENT COVERAGE

# A. Claims-Made Coverage

The calculations for changes in exposure are performed by taking the difference between claims-made rates for each period of differing exposures. These calculations are appropriate for changes in practice specialty, changes in rating territory or practice in other states, changes between part-time and full-time practice, and other changes that would affect a calculated rate. Currently approved rates, classification tables and discount or surcharge factors for the appropriate state(s) are used. This method can be generalized by using the following formula to calculate a rate for the upcoming year.

- 1. Rate for current practice, determined using a retroactive date equal to the date that the *current* practice patterns began,
- 2. plus rate for prior practice, determined using a retroactive date equal to the date that the *previous* practice patterns began,
- 3. less rate for prior practice, determined using a retroactive date equal to the date that the *current* practice patterns began.

This method is applied in a similar manner if more than one practice change occurred during the previous four years, and the components are pro-rated if the change occurred at a date other than the policy anniversary date.

For example, if a dentist had practiced general dentistry with cosmetic Botox for many years, then stopped practicing cosmetic Botox and began to practice general dentistry-no surgery only, the appropriate premium for the upcoming policy period would be:

General dentist-No surgery rate for claims-made year one, plus General dentists, Cosmetic Botox rate for claims-made year five, less General dentists, Cosmetic Botox rate for claims-made year one.

This produces a blended rate, reflecting the remaining General dentists, Cosmetic Botox exposure that makes up the majority of the expected reported claims in the upcoming year, plus the initial General dentist-No surgery exposure.

The rate for the second year of gynecology-only practice would be:

General dentist-No surgery rate for claims-made year two, plus General dentists, Cosmetic Botox rate for claims-made year five, less General dentists, Cosmetic Botox rate for claims-made year two.

This adjustment process continues for two more years, until the beginning of the fifth year in the new specialty. At that time, the blended rate would be:

General dentist-No surgery rate for claims-made year five, plus General dentists, Cosmetic Botox rate for claims-made year five, less General dentists, Cosmetic Botox rate for claims-made year five, which is simply equal to the General dentist-No surgery rate for claims-made year five.

Although this method of adjusting rates is designed to accommodate most situations, changes in dental practice often result from increasing or decreasing patient loads, additional dental training, relocation of the practice, gradual reduction in practice nearing retirement and other underwriting factors which affect the risk of loss. As a result, the Company may choose to waive the exposure change adjustment process in specific situations, thereby utilizing the current rating variables without modification. Conversely, a debit under the Scheduled Rating Plan may be applied at the underwriter's discretion, based on more than five years of practice in specialties with long claim emergence patterns.

#### B. Prior Acts Coverage

When prior acts coverage is provided, the same method is utilized, as if the insured had been with the Company during the prior acts period. Practice information regarding the prior acts period is obtained from the insurance application.

# C. Reporting Endorsement Coverage

If reporting endorsement coverage is to be rated, the same method is utilized, substituting the reporting endorsement rates for the claims-made rates. For example, a reporting endorsement purchased at the end of the second year of general dentist-no surgery practice in the general dentists, cosmetic Botox example described above would be:

general dentist-no surgery reporting endorsement premium for claims-made year two, plus general dentists, cosmetic Botox reporting endorsement premium for claims-made year five, less general dentists, cosmetic Botox reporting endorsement premium for claims-made year two.

# D. Occurrence Coverage

The calculations for changes in exposure are performed by prorating the rates for the periods of differing exposures. These calculations are appropriate for changes in practice specialty, changes in rating territory or practice in other states, changes between part-time and full-time practice, and other changes that would affect a calculated rate. Currently approved rates, classification tables and discount or surcharge factors for the appropriate state(s) are used.

Although this method of adjusting rates is designed to accommodate most situations, changes in dental practice often result from increasing or decreasing patient loads, additional dental training, relocation of the practice, gradual reduction in practice nearing retirement and other underwriting factors which affect the risk of loss. As a result, the Company may choose to waive the exposure change adjustment process in specific situations, thereby utilizing the current rating variables without modification. Conversely, a debit under the Scheduled Rating Plan may be applied at the underwriter's discretion, based on more than five years of practice in specialties with long claim emergence patterns, such as Pediatrics or Obstetrics.

# VI. REPORTING ENDORSEMENTS (Claims-made only)

# A. Reporting Endorsement Premium Calculation

With respect to calculation of Reporting Endorsement premium, all credits/discounts, with the exception of the New Doctor or Dentist Discount, and all debit/surcharges will apply to Reporting Endorsement premium calculations. With respect to risks or exposures written on a (a) rated basis or Full-Time Equivalent Rating basis at the time the Reporting Endorsement is issued, Reporting Endorsement premium will be calculated on that same basis. If the policy is terminated during the first year, pro-rate the tail premium. For terminations during the second, third or fourth claims-made policy year, blend the applicable tail factors. The Company may refuse to offer deductible options for premium credit on reporting endorsements in the case of insufficient securitization.

# B. Waiver of Reporting Endorsement Premium

The premium for the reporting endorsement may be waived as provided by the contract in force.

# SECTION 3 PROFESSIONAL LIABILITY DISCOUNTS

# PROFESSIONAL LIABILITY DISCOUNTS

#### I. MAXIMUM CREDIT

Maximum credit available per insured will be limited to 25% except for the following:

- Part-time exposure rating: up to 50%. Deductible credits and attendance of a ProAssurance Loss Prevention Seminar credit may be combined with the part-time credit but no other credits or discounts apply.
- New Dentist Discounts: up to 60%. Deductible credits may be combined with the New Dentist Discount but no other credits or discounts apply.
- Deductibles/Self-Insured Retentions.

#### II. NEW DENTIST DISCOUNT

This discount will apply only to solo practicing dentists who have never been in practice and proceed directly into practice from training, or dentists who fit within that category except for an interim period of employment not to exceed two years. Dentists who would otherwise qualify but who are joining an established group practice insured by the Company where their clinical exposure will not exceed 30 hours per week credited as if they have had one additional year of practice. This discount will also apply only to dentists who proceed directly into practice from training, or dentists who fit within the category except for an interim period of employment not to exceed two years.

Year of Coverage	<b>Annual Premium Discount per Policy</b>
Since Training	<u>Dentists</u>
Year 1	60%
Year 2	40%
Year 3	0%

Note that these discounts do not apply to occurrence or extended reporting endorsement rates.

#### III. SCHEDULED RATING PROGRAM

The Company has determined that significant variability exists in the hazards faced by dentists engaged in the practice of dentistry. Exposure conditions vary with respect to:

	<u>Activity</u>	Credit
1.	Number of years experience in dentistry;	0% to -5%
2.	Number of patient exposures;	-5% to 5%
3.	Organization (if any) and size;	-5% to 5%
4.	Dental standards review and claims review committees;	-10% to 10%
5.	Other risk management practices and procedures;	-10% to 10%
6.	Training, accreditation and credentialing;	-10% to 10%
7.	Continuing Dental Education activities;	-5% to 5%
8.	Professional liability claim experience;	-10% to 10%
9.	Record-keeping practices;	-10% to 10%
10.	Maintenance and utilization of certain monitoring equipment, diagnostic	ostic tests or diagnostic
	procedures;	-5% to 5%
11.	Participation in capitation contracts; and*	0% to 25%
12.	Insured group maintains differing limits of liability on members.*	0% to 25%
13.	Services provided at correctional facilities, nursing homes or	0% to 25%
	mobile dental units.	

In order to recognize these and other factors affecting a particular practitioner or group practice, the Company proposes to apply a debit or credit to the otherwise applicable rate dependent upon the underwriter's overall evaluation of the risk.

The maximum credit will be 25%; the maximum debit will be 25%.

The Scheduled Rating Plan will apply to individuals as well as groups of two or more dentists as the Company becomes aware of variability in the risk characteristics of the individual or group. At the underwriter's discretion, objective credits otherwise applicable to an insured will not be applied in situations where a scheduled debit is deemed necessary.

\* NOTE: No credit will be given for #11, #12 or #13 above.

#### IV. DEDUCTIBLES

Deductibles are available to dentists only and may apply either to indemnity only, to indemnity <u>and</u> allocated loss adjustment expenses (ALAE), or to indemnity and ALAE and supplemental payments. Any discount will apply only to the primary limit premium layer (\$1M/\$3M). Deductibles are subject to approval by the company based on financial statements to be submitted by the insured and financial guarantees as required. The company reserves the right to require acceptable securitization in the amount of the per claim or per incident and/or aggregate deductible amount from any insured covered by a policy to which a deductible is attached.

#### A. Individual Deductibles

#### Discount as a Percentage of Rate for Applicable Primary Limit

These per incident and aggregate (if any) deductibles apply to each insured separately.

INDEMNIT  Deductible P		INDEMNITY <u>Deductible</u>	AND ALAE Per Incident
\$ 1,000	2.4%	\$ 1,000	3.0%
\$ 2,000	4.8%	\$ 2,000	6.1%
\$ 5,000	8.5%	\$ 5,000	10.6%
\$10,000	10.9%	\$10,000	13.6%
\$25,000	16.9%	\$25,000	21.20%
\$50,000	21.8%	\$50,000	27.2%
\$75,000	27.8%	\$75,000	34.8%
\$100,000	33.9%	\$100,000	42.4%
\$150,000	41.1%	\$150,000	51.4%
\$250,000	48.4%	\$250,000	60.5%
\$400,000	53.2%	\$400,000	66.6%
\$500,000	60.5%	\$500,000	75.60%

Per Incident/Agg	gregate	Per Incident/Agg	<u>gregate</u>
\$ 1,000/ 3,000	2.2%	\$ 1,000/ 3,000	2.8%
\$ 2,000/ 6,000	4.4%	\$ 2,000/ 6,000	5.5%
\$ 5,000/15,000	7.7%	\$ 5,000/15,000	9.6%
\$10,000/30,000	9.9%	\$10,000/30,000	12.4%
\$25,000/75,000	15.4%	\$25,000/75,000	19.3%
\$50,000/150,000	19.8%	\$50,000/150,000	24.8%
\$75,000/225,000	25.3%	\$75,000/225,000	31.6%
\$100,000/300,000	30.8%	\$100,000/300,000	38.5%
\$150,000/450,000	37.4%	\$150,000/450,000	46.8%
\$250,000/750,000	44.0%	\$250,000/750,000	55.0%
\$400,000/1,200,000	48.4%	\$250,000/750,000	60.5%
\$500,000/1,500,000	55.0%	\$250,000/750,000	68.8%

For deductible to apply per certificate holder, apply a factor of 1.100 to the appropriate deductible factor. For other deductible amounts selected by policyholders, refer to management for rating.

# B. Group Deductibles

An optional deductible which limits the amount the entire group will have to pay, if multiple claims are made in a policy year, is available. Under this program, the per incident deductible continues to apply separately to each insured involved in a suit. However, the aggregate deductible applies to all insureds in the group combined thereby reducing the organization's maximum potential liability in a policy year.

When an organization is insured with a separate limit of coverage, the organization is counted when totaling the number of insureds below.

Group aggregate deductible discounts apply to \$1M/\$3M premiums only. The applicable Deductible Discount will not change during the policy term despite changes in the number of insureds, but will be limited by any applicable maximum credit amount.

Indemnity Deductible	<b>;</b>				
Per Incident/Aggrega	te	Number	of Insur	<u>eds</u>	Maximum
(\$000)	<u>2 - 19</u>	<u>20 - 40</u>	<u>41 - 60</u>	<u>61 - 100</u>	<u>Credit</u>
5/15	.073	.066	.055	.044	\$ 12,750
10/30	.096	.089	.076	.061	25,500
25/75	.152	.143	.127	.105	63,750
50/150	.205	.197	.180	.154	127,500
100/300	.300	.293	.277	.252	255,000
250/750	.424	.424	.419	.405	637,500
Indemnity & ALAE					
Deductible			0.7		3.5
Per Incident/Aggrega		<u>Number</u>			Maximum
(\$000)	<u>2 - 19</u>	<u>20 - 40</u>	<u>41 - 60</u>	<u>61 - 100</u>	Credit
5/15	.093	.083	.067	.055	\$ 12,750
10/30	.120	.111	.095	.076	25,500
25/75	.191	.180	.159	.132	63,750
50/150	.256	.246	.224	.193	127,500
100/300	.375	.366	.347	.314	255,000
250/750	.530	.530	.524	.506	637,500

# C. Mandatory Deductibles

The deductible mechanism may be applicable when a policyholder exhibits a pattern of claim frequency that exceeds the average for his/her specialty. In the consideration of a deductible assessment, severity is usually not an issue.

Deductibles may be imposed in amounts from \$1,000 to \$250,000 per claim. There is no corresponding premium discount, and there are no aggregate limits on mandatory deductibles.

An amendatory deductible endorsement will be added to the policy at renewal and will be maintained for no less than one year. The policy will be subject to an annual review thereafter for consideration of a revised sanction.

# V. GENERAL RULES

- A. Discounts will only be applied to qualifying insureds at the initial issuance of such policy or at the next renewal date.
- B. Discounts will apply in the following order:
  - 1. Deductible Discount (primary premium only).
  - 2. All other discounts.
- C. Additional practice charges will be applied to the premium after all discounts have been applied.
- D. Corporate Liability premium will be determined after all discounts and surcharges have been applied.

# **SECTION 4**

ADDITIONAL PRACTICE CHARGES

# ADDITIONAL PRACTICE CHARGES

# I. DENTAL SERVICES PROVIDED IN A STATE OUTSIDE THE STATE OF POLICY ISSUANCE

Insureds engaging in the routine care and treatment of patients outside the state in which the policy is issued may be subject to appropriate surcharge or credit based upon rates consistent with those charged for a like risk in said state.

#### II. PARTNERSHIP - CORPORATION - PROFESSIONAL ASSOCIATION COVERAGE

Coverage for partnerships, corporations, or professional associations may be written with a separate limit of liability. The premium charge will be a percentage (selected from the table below) of the sum of each member dentist's net individual premium. The minimum premium charge for this coverage is \$100 for dental. However, this minimum premium may be waived for a specific market or program applying to eligible members of an association. For each member dentist not individually insured by the Company, a premium charge for vicarious liability will be made equal to 30% of the appropriate specialty rate if the Company agrees to provide such coverage. In order for the entity to be eligible for coverage under the separate policy, the Company must insure all member dentists, or at least 60% of the dentist members must be insured by the Company and the remaining dentists must be insured by another professional liability program acceptable to the Company.

# of Insureds	\$1M/\$3M Charge	\$500K/\$1M	\$200K/\$600K	\$100K/\$300K
1	N/A	N/A	N/A	N/A
2 – 5	10.0%	18.0%	24.0%	26.0%
6 – 9	10.0%	17.0%	22.0%	24.0%
10 – 19	9.0%	13.0%	18.0%	20.0%
20 – 49	7.0%	9.0%	14.0%	16.0%
50 or more	5.0%	7.5%	10.5%	11.5%

# III. PARTNERSHIP-CORPORATION-PROFESSIONAL ASSOCIATION EXTENDED REPORTING ENDORSEMENT COVERAGE

Partnerships, corporations, or professional associations that purchase a separate limit of liability may be eligible to purchase an Extended Reporting Endorsement upon cancellation of the coverage. The premium charge for the entity extended reporting endorsement will be a percentage of the sum of each member dentist's net individual reporting endorsement premium, based on the number of insureds and the table in Paragraph II, above.

#### IV. CLAIMS FREE CREDIT PROGRAM

A dentist will be considered claims free for purposes of this credit program if:

- 1. no loss payment has been made during the Evaluation Period, and
- 2. the total of allocated loss adjustment expense [ALAE] payments made during the Evaluation Period plus any Company established reserves for loss or ALAE does not exceed \$35,000.

Only claims reported during the Evaluation Period shall be included in measuring the payment and reserve criteria stated above. The Evaluation Period is based upon the dentist's rating class as defined in the table below and shall end on the effective date of the policy period to be rated. The Evaluation Period shall begin no earlier than the time when the dentist first begins the practice of dentistry following formal training (residency or a continuous period of residency and fellowship). The Company will review the claims history of each insured or applicant for the purpose of evaluating the applicability of each claim based upon the facts and circumstances of specific claims. Reported incidents that do not involve a demand for damages by a third party will not be included in the evaluation.

Dentist Class Evaluation Period

1A - 5 10 Yrs.

The claims free dentist will receive a 3% credit for compliance with the minimum Claims Free Period and will earn an additional 1% credit for each continuous claims free year thereafter up to 15% in total. However, if the dentist has been continuously insured by the Company for 10 or more years, the maximum allowable Claims Free Credit that can be earned will be increased to 20%.

Credits will be applied or removed at policy inception or renewal only. Inclusion of claims history with prior carriers is subject to presentation of information acceptable to the Company. The determination of claims to be included and payment or reserve amounts to be considered will be based upon information available at the time the policy is rated, typically 60 days prior to effective date.

Dentists will be treated as "Class 1" for determination of their Evaluation Period and will be eligible for a maximum Claims Free Credit of 15%, in accordance with the earning schedule above. However, the Claims Free Dentist must have no incurred losses or ALAE (payments or reserves) during the Evaluation Period. Notwithstanding any other provisions of this section, no dentist with 2 or more reported claims will be eligible for a claims free credit without management approval.

#### V. LEGAL DEFENSE COVERAGE

The Company offers the Professional Legal Defense Extended Coverage to insured dentists at no charge.

Limits of Liability will be offered as follows:

# of insureds	"Each Covered Inv	vestigation" "Each Policy Period"
1 - 5	\$25,000	\$25,000 X (# of insureds
6 - 10	\$25,000	\$125,000
11 - 20	\$25,000	\$175,000
21 +	\$25,000	\$225,000

The limit of liability for "covered audits" will be \$5,000 per covered insured with a deductible of \$1,000 per audit per insured.

#### **SECTION 5**

PHYSICIAN EXTENDER, PARAMEDICAL AND ALLIED HEALTH PROFESSIONAL LIABILITY RATING

# I. PHYSICIAN EXTENDER, PARAMEDICAL, ALLIED HEALTH EMPLOYEE PROFESSIONAL LIABILITY

Professional employees (other than dentists, certified registered nurse anesthetists, nurse practitioners, physicians, physicians' assistants, surgeons, surgeons' assistants, advanced practice nurse prescribers) are automatically included, at no additional charge, as additional insureds under policies issued to their employers. The limits of liability are on a shared basis with the employer.

The following paramedical employees may be individually covered by the Company by payment of an additional premium or covered elsewhere through a program deemed acceptable to the Company with minimum limits of liability equal to or greater than those of the insured employer. Coverage is available on a shared-limits basis or with separate individual limits. To determine the additional premium for the coverage selected, apply the appropriate factor from the premium assigned to dentist Class Code 80211, as specified, for the applicable claims-made year and limits of liability:

(Paramedical employees written on a shared-limits basis will be charged a fourth year claims-made premium regardless of retroactive date and the shared-limits factors stated above will always be applied to a fourth year claims-made premium.)

	(Factors based on 80211)			
Employee	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor	
Physician Assistant (PA)	0.1684	0.765	0.1473	
Surgeon's Assistant (SA)	0.1684	0.765	0.1473	
Certified Nurse Practitioner (CNP)	0.1684	0.765	0.1473	
Advanced Practice Nurse Prescriber (APNP)	0.1684	0.765	0.1473	

	(Factors based on 80211)			
Employee	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor	
Certified Nurse Anesthetist (CRNA) – not part of an insured group	N/A	1.540	0.186	
CRNA employed by an insured group - separate limits basis	N/A	1.025	0.133	
CRNA employed by an insured group – shared limits basis with ratio of CRNAs to anesthesiologists between 2:1 and 4:1	N/A	N/A	N/A	
CRNA employed by an insured group – shared limits basis with ratio of CRNAs to anesthesiologists no more than 2:1	N/A	N/A	N/A	

**NOTE**: When the limits of liability apply on a shared basis with the dentists of the group, the premium charge for the excess limits for the paramedical employees will be calculated at the level that the majority of dentists carry.

#### II. ALLIED HEALTH PROFESSIONAL EMPLOYEES

Certain Allied Health professionals are eligible for separate insurance by the Company at individual limits of liability. The premium charge will be determined by applying the factors below to the appropriate rate for the designated Dentist Class Code in the applicable rating territory.

#### **STEP-RATING FACTORS**

First Year	50% of mature premium
Second Year	80% of mature premium
Third Year	100% of mature premium

SPECIALTY	CLASS CODE	\$1M/\$3M
		(Factors based on 80211)
Physician Assistant	80116	0.765
Surgeon Assistant	80116(B)	0.765
Certified Registered Nurse Anesthetist	80960	1.540
Dental Assistant	80207	0.018
Dental Hygienist	80208	0.018

At the discretion of the underwriter, additional insured status may be granted to the non-insured allied health entity for a 10% additional charge. The entity will share in the limits of liability of the insured allied health provider but only for the activities of such provider but only for the activities of such provider.

Mature premiums under \$500 are not eligible for the step-rating factors.

#### Reporting Endorsements:

Reporting Endorsements are available to Allied Health Professionals insured under separate policies by application of the factors below.

Prior Year Claims-Made	<u>Factors</u>
1	1.00
2	1.25
3+	1.50

# **SECTION 6**

DENTAL PROFESSIONAL LIABILITY SPECIALTY CODES AND DESCRIPTIONS

#### DENTAL SPECIALTY CODES & CLASSIFICATIONS

\*

#### **DENTISTS - CLASS 1A**

Applies to dentists who perform dentistry on patients who have been treated with local anesthesia or by inhalation sedation and does not apply to treatment involving any general anesthesia or intravenous or intramuscular agent unless performed in a hospital.

This class does not apply to dentists performing extractions, root canals or other oral surgery or endodontic procedures. This class does not apply to oral surgeons.

#### **DENTISTS - CLASS 1**

- Applies to dentists who perform dentistry on patients who have been treated with local anesthesia or by inhalation sedation and does not apply to treatment involving any general anesthesia or intravenous or intramuscular agent unless performed in a hospital. This class does not apply to dentists performing the initial placement of dental implants. This class does not apply to oral surgeons.
- Applies to orthodontists and endodontists who perform dentistry on patients who have been treated with local anesthesia or by inhalation sedation and does not apply to treatment involving any general anesthesia or intravenous or intramuscular agent unless performed in a hospital. This class does not apply to dentists performing the initial placement of dental implants. This class does not apply to oral surgeons.
- Applies to periodontists who perform dentistry on patients who have been treated with local anesthesia or by inhalation sedation and does not apply to treatment involving any general anesthesia or intravenous or intramuscular agent unless performed in a hospital. This class does not apply to dentists performing the initial placement of dental implants. This class does not apply to oral surgeons.

#### **DENTISTS - CLASS 2**

- Applies to dentists, endodontists and periodontists as defined for Class 1 but, in addition, permits the initial placement of dental implants.
- Applies to dentists, endodontists and periodontists as defined for Class 1 but, in addition, permits dentistry on patients who have been treated by intravenous or intramuscular sedation in the office, but only if the sedation is administered by a Dental or Medical Anesthetist. If intravenous or intramuscular sedation is performed in a hospital only, Class 1 will apply. This class does not apply to oral surgeons.

#### **DENTISTS - CLASS 3**

Applies to dentists as defined for Classes 1 or 2 but, in addition, permits dentistry on patients who have been treated by intravenous or intramuscular sedation in the office, administered by the dentist or a CRNA. If intravenous or intramuscular sedation is performed in a hospital only, Class 1 or 2 will apply, as appropriate. This class does not apply to oral surgeons.

#### ORAL SURGERY - CLASS 4

Includes all oral surgeons and also applies to dentists as defined in Classes 1A through 3 who additionally perform dentistry on patients who are being treated with general anesthesia in the office.

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#### **DENTISTS - CLASS 5**

Applies to dentists as defined for Classes 1 or 2 but, in addition, permits use of cosmetic Botox on patients who have been treated by intravenous or intramuscular sedation in the office, administered by the dentist or a CRNA. This class does not apply to oral surgeons.

#### PARADENTAL EMPLOYEE COVERAGE

Coverage on a shared limits basis is automatically provided for professional employees of the Policyholder or an insured under the policy with no additional charge (e.g., dental assistants, dental hygienists and lab technicians).

While a dental insured's insured paradental employees are automatically covered under the policy, a premium charge for Certified Registered Nurse Anesthetists (CRNAs) will be made as indicated in Section 6, I – Employed Certified Registered Nurse Anesthetist.

# **SECTION 7**

STATE RATES AND EXCEPTIONS – DENTISTS

# I. RATES

# A. Dental Rating Classes – Illinois

The following indicates the specialty classification codes applicable to the rating classes on the following pages:

1A	80213
1	80211
	80214
	80215
2	80211(F)
	80211(G)
3	80209
4	80210
5	80211(I)

# **B.** Dentists Professional Liability Rates

# 1. Claims-Made Rates by Year

Territory 1: Cook, Lake, Monroe, St. Clair and Will counties

	\$100,000 / \$300,000				
Class Code	1	2	3	4	5+
1A	400	565	675	780	890
1	450	660	795	915	1,040
2	450	660	795	915	1,040
3	850	1,365	1,705	1,945	2,180
4	1,915	3,250	4,140	4,680	5,220
5	4,175	7,255	9,305	10,445	11,585
		\$200	,000 / \$600,000		
Class Code	1	2	3	4	5+
1A	420	600	720	835	950
1	480	705	855	985	1,115
2	480	705	855	985	1,115
3	920	1,480	1,860	2,115	2,370
4	2,090	3,555	4,535	5,125	5,715
5	4,575	7,960	10,220	11,470	12,725
		\$500,	000 / \$1,000,000		
Class	1	2	2	4	<b>5</b> .
Code	1		3	4	5+
1A	470	690	835	960	1,090
1	540	815	995	1,145	1,290
2	540	815	995	1,145	1,290
3	1,070	1,755	2,210	2,505	2,805
4	2,485	4,260	5,445	6,145	6,850
5	5,495	9,585	12,315	13,830	15,350
		\$1,000	,000 / \$3,000,000		
Class Code	1	2	3	4	5+
				<u> </u>	
1A	515	770	940	1,080	1,220
1	600	915	1,130	1,295	1,460
2	600	915	1,130	1,295	1,460
3	1,215	2,010	2,540	2,885	3,225
4	2,865	4,935	6,310	7,125	7,935
5	6,370	11,140	14,320	16,090	17,855
100 07 11	- ,	Effective January 1,		,	Page 2

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# 1. Claims-Made Rates by Year (cont.)

Territory 2: Remainder of State

	\$100,000 / \$300,000				
Class Code	1	2	3	4	5+
1A	350	475	560	655	745
1	390	550	655	760	865
2	390	550	655	760	865
3	700	1,095	1,355	1,550	1,740
4	1,515	2,540	3,225	3,655	4,080
5	3,255	5,625	7,200	8,080	8,955
		\$200	,000 / \$600,000		
Class Code	1	2	3	4	5+
1A	365	505	600	695	795
1	410	585	700	810	925
2	410	585	700	810	925
3	750	1,185	1,475	1,680	1,885
4	1,650	2,780	3,530	3,995	4,460
5	3,565	6,165	7,905	8,870	9,835
		\$500,0	000 / \$1,000,000		
Class Code	1	2	3	4	5+
				<u> </u>	
1A	405	570	685	795	900
1	460	670	810	935	1,055
2	460	670	810	935	1,055
3	865	1,390	1,740	1,980	2,225
4	1,955	3,320	4,230	4,780	5,335
5	4,270	7,415	9,515	10,685	11,850
		\$1,000	,000 / \$3,000,000		
Class Code	1	2	3	4	5+
1A	440	635	765	885	1,005
1	505	750	910	1,050	1,185
2	505	750	910	1,050	1,185
3	980	1,590	2,000	2,270	2,545
4	2,250	3,840	4,900	5,535	6,170
5	4,945	8,615	11,060	12,420	13,780

# 2. Reporting Endorsement Rates by Year

Territory 1: Cook, Lake, Monroe, St. Clair and Will counties

		\$100,000 / \$300,000				
Class Code	1		2	3	4	5+
1A 1		573 670	868 1,014	1,026 1,199	1,103 1,289	1,140 1,332
2		670 670	1,014	1,199	1,289	1,332
3		404	2,126	2,514	2,701	2,793
4		362	5,090	6,019	6,468	6,687
5	7,	461	11,295	13,358	14,354	14,840
			\$20	0,000 / \$600,000		
Class Code	1		2	3	4	5+
1A		612	926	1,095	1,177	1,217
1		718	1,087	1,286	1,381	1,428
2 3		718	1,087	1,286	1,381	1,428
		526	2,311	2,733	2,936	3,036
4		680	5,572	6,589	7,081	7,321
5	8,	195	12,407	14,672	15,766	16,301
Class			\$500	0,000 / \$1,000,000	)	
Class Code	1		2	3	4	5+
1A	702		1,063	1,257	1,351	1,396
1	831		1,258	1,487	1,598	1,652
2	831		1,258	1,487	1,598	1,652
3	1,806		2,735	3,234	3,475	3,593
4 5	4,411 9,885		6,679 14,966	7,898 17,699	8,487 19,019	8,775 19,663
	7,000		,	0,000 / \$3,000,00		19,000
Class			41,00	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
Code	1		2	3	4	5+
1A		786	1,190	1,407	1,512	1,563
1		940	1,424	1,683	1,809	1,870
		940	1,424	1,683	1,809	1,870
2 3		077	3,144	3,718	3,996	4,131
4	5,	110	7,737	9,149	9,831	10,165
5	11,	499	17,409	20,587	22,122	22,872

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# 2. Reporting Endorsement Rates by Year (cont.)

Territory 2: Remainder of State

		\$100,000 / \$300,000			
Class Code	1	2	3	4	5+
1A	480	726	859	923	954
1	557	843	997	1,072	1,108
2	557	843	997	1,072	1,108
3	1,121	1,697	2,006	2,156	2,229
4	2,628	3,978	4,704	5,055	5,226
5	5,767	8,731	10,325	11,095	11,471
		\$200.	,000 / \$600,000		
Class Code	1	2	3	4	5+
1.4			017	007	1.010
1A	512	775	917	985	1,018
1	596	902	1,067	1,146	1,185
2	596	902	1,067	1,146	1,185
3	1,214	1,838	2,173	2,336	2,415
4 5	2,872	4,349	5,142	5,526	5,713
3	6,334	9,589	11,340	12,186	12,599
Class		\$500,0	000 / \$1,000,000		
Code	1	2	3	4	5+
1A	580	878	1,038	1,115	1,153
1	679	1,029	1,216	1,307	1,351
2	679	1,029	1,216	1,307	1,351
3	1,433	2,169	2,565	2,757	2,850
4	3,436	5,202	6,151	6,610	6,834
5	7,631	11,554	13,663	14,682	15,180
		\$1,000	,000 / \$3,000,000		
Class Code	1	2	3	4	5+
1A	647	980	1,159	1,245	1,287
1	763	1,155	1,366	1,468	1,518
2	763	1,155	1,366	1,468	1,518
3	1,639	2,481	2,934	3,153	3,260
4	3,973	6,016	7,114	7,645	7,904
5	8,874	13,436	15,888	17,073	17,652
5	0,07	13,430	13,000	11,013	17,032

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# 3. Occurrence Rates by Year

Territory 1: Cook, Lake, Monroe, St. Clair and Will counties

Class Code	100/300	200/600	500/1500	1000/3000
1A	1,015	1,090	1,260	1,425
1	1,200	1,295	1,510	1,720
2	1,200	1,295	1,510	1,720
3	2,610	2,845	3,385	3,905
4	6,370	6,980	8,385	9,730
5	14,360	15,770	19,010	22,115

Territory 2: Remainder of State

Class Code	100/300	200/600	500/1500	1000/3000
1A	840	900	1,030	1,160
1	985	1,055	1,225	1,380
2	985	1,055	1,225	1,380
3	2,070	2,250	2,665	3,065
4	4,960	5,430	6,510	7,545
5	11,105	12,190	14,685	17,070

#### **4. Excess Limits Premium Factors**

Excess limits premium shall be derived by applying the appropriate factor below to the appropriate primary rate. Excess limits are only offered above underlying limits of \$1,000,000.

\$1M/\$3M Primary

<b>EXCESS</b>	Dentists/
LIMITS	Oral Surgeons
\$1M	0.0480
\$2M	0.0960
\$3M	0.1450
\$4M	0.1935
\$5M	0.2225

These factors are based upon negotiated reinsurance agreements. Deviation from these factors up to 25% based upon negotiated agreements with reinsurers and/or underwriting judgment may apply.

#### II. EXCEPTIONS

#### A. Policy Issuance

- 1. If the insured elects to accept the Waiver of Consent to Settle Endorsement, Form PRA-HCP-612, a credit of 7% will be applied.
- 2. The Illinois State Amendatory Endorsement must be attached to the policy at the time of issuance.
- 3. Item III, Premium Payments, is hereby added to Section 1, Introduction, as follows:

#### III. PREMIUM PAYMENTS

- 1. Annual Payment Plan The premium must be paid in full prior to the inception date of the policy.
- 2. Semi-Annual Payment Plan -60% of the premium must be paid prior to the policy inception date and one installment of 40% is due six months after inception.
- 3. Quarterly Payment Plan -35% of the premium must be paid prior to the policy inception date, with second and third quarterly payments of 25% each and a final quarterly payment of 15%.
- 4. Nine Payment Plan 20% down and eight consecutive monthly installments of 10% each. This plan requires that the policyholder participate in the Electronic Payment Plan in which premiums are automatically deducted from the policyholder's bank account.

No finance charges or fees apply to these payment plans. The option to pay premium on other than the Annual Payment Plan may be withdrawn by the Company if the insured has failed to make premium payments when due.

#### B. Rules

1. Section 3, Professional Liability Discounts, is amended by adding the following:

#### VI. BLENDING CREDIT OR DEBIT

A blending credit is available for those accounts that are rated in one territory, but have a percentage of their practice in another (one or more) territory. This credit is intended to bring the premium in line with the exposure per territory. It is not intended to reduce the premium below that of which they would pay in the outside territory. The Named Insured must provide a complete distribution of their practice. This distribution may include percentages for office and hospital practice along with a further breakdown into territory for each facet. This information must be completed in order to provide an accurate credit.

2. Section 3, Professional Liability Discounts, is amended by adding the following:

#### VII. GROUP PRACTICE MODIFICATION PLAN

Credits or debits for groups will be determined annually on the basis of our evaluation of each individual group's risk profile, which assesses such characteristics as changes in maturity, number of healthcare providers, specialty composition, management, employees, patient records, quality assurance, facilities, billing procedures and loss history.

#### **Group Practice Eligibility**

- 1. a. For a group of dental healthcare providers, two or more permanently licensed, practicing dentists.
  - b. Other markets are not eligible for group practice (entity) policies or rating, unless specifically addressed in this manual.

- 2. Group must be a corporation, partnership, joint venture, or limited partnership association.
- 3. Primary location where both professional services are rendered and administrative functions (billing, patient records) are undertaken.
- 4. Satellites are acceptable to the extent they are controlled and are practicing as part of the primary location.
- 5. The entity must be organized for the purpose of delivering professional services to patients.

#### **Group Practice Primary Evaluation Criteria**

- 1. Length of time entity has operated as a group.
- 2. Degree of specialization within the group.
- 3. Stability of members and locations.
- 4. Reputation and standard within the community served.
- 5. Promotional materials, advertising, sign on the door.
- 6. Hospitals where healthcare provider(s) has admitting privileges.

#### **Group Practice Risk Profile**

This risk profile should ascertain the level of the group's involvement and commitment in their effort to provide risk management. It is the Company's philosophy that the greater effort clinics use to reduce risk, the more awareness they have of methods to limit the exposure to malpractice litigation. If properly instituted, a good risk management program will:

- 1. Reduce the risk of malpractice claims by the recognition and elimination of problem areas:
- 2. Augment a defensible position;
- 3. Increase awareness of potential areas of risk;
- 4. Improve the standard of care;
- 5. Provide a mechanism for patient advocacy.

#### **Group Practice Claims History Evaluation**

This evaluation ascertains the level of the group's prior claims and loss history and to obtain the appropriate claim information and assess the liability, if any, of a healthcare provider. To make the assessment, identify the following factors:

- 1. Did the healthcare provider depart from the accepted standard of care? Did that departure result in injury, loss, or damage to the patient?
- 2. What was the opinion of the peer review committee, if any, or experts who reviewed the case as to the standard of care rendered?
- 3. Are there any patterns or trends noted in the healthcare provider's practice which could give rise to subsequent professional incidents, such as the same surgical procedure improperly performed, inadequate patient histories or workups, lack of informed consent, improper record keeping and documentation, etc.?
- 4. Assess the number of claims which have occurred from inception of the healthcare provider's practice. Evaluate those that have occurred against the nature of the insured's specialty.
- 5. If a renewal, review the claim representative's case summary, trial review or other evaluation report for their assessment of the merits of the case. Often the Litigation Specialist is in contact with the healthcare provider and is the most knowledgeable of the facts in the case. Did the healthcare provider cooperate with the Litigation Specialist and the Company in preparing the defense?

Upon evaluation of these factors, either a decision or a recommendation for coverage will be formed by the Underwriter.

#### **Non-Group Primary Evaluation Criteria**

- 1. Length of time healthcare provider(s) has practiced;
- 2. Stability of practice;
- 3. Reputation and standing within the community served;
- 4. Hospitals where healthcare provider(s) has admitting privileges;

#### **Non-Group Risk Profile**

This risk profile should ascertain the level of the healthcare provider's involvement and commitment in their effort to provide risk management. It is the Company's philosophy that the greater effort healthcare providers use to reduce risk, the more awareness they have of methods to limit the exposure to malpractice litigation. If properly instituted, a good risk management program will:

- 1. Reduce the risk of malpractice claims by the recognition and elimination of problem areas:
- 2. Augment a defensible position;
- 3. Increase awareness of potential areas of risk;
- 4. Improve the standard of care;
- 5. Provide a mechanism for patient advocacy.

The maximum credit or debit is 25 percent for dentists, based on the eligibility, primary evaluation criteria, risk profile and loss ratio evaluation, as described in the rules pages.

The combined credit/debit for the Schedule Rating Program and the Group Practice Modification Plan cannot exceed 25%.

3. Section 3, Professional Liability Discounts, is amended by adding the following

First Aid Coverage – Standard coverage will be offered with a sublimit of \$5,000.

4. Section 4, Professional Liability Discounts, is hereby amended by replacing Item IV, Claims Free Credit Program, with the following:

#### V. LOSS FREE DISCOUNT PROGRAM

<u>Loss-Free Credit</u>: Healthcare providers who have not experienced losses may be able to receive premium credits as follows:

# Of Loss-Free	Annual	Accumulated
Years	<u>Credit</u>	Credit
1	5%	5%
2	10%	10%
3	15%	15%

<u>New Business</u>: Dentists who have been loss-free (with no indemnity payments) for the past three years will receive the full premium credit of 15 percent. Dentists who have been loss-free for two years will receive a 10 percent credit, while dentists with one year of loss-free experience will receive a 5 percent credit.

<u>Definition of a Meritorious Claim:</u> If any one claim results in an indemnity payment of more than \$3,000 for dentists or all other healthcare providers, the premium for the healthcare provider will revert to the base level. Otherwise, loss-free credits will continue to apply and accumulate, subject to the maximum available credit, as well as Underwriting review.

<u>If a Loss (As Defined) Occurs After Enrollment Into the Program:</u> In this situation, the rates upon renewal revert back to the 100 percent level until the health care provider has been loss free for a full policy year, at which time credits again begin to accumulate.

5. Section 4, Professional Liability Discounts, is hereby amended by adding the following:

#### V. DENTISTS RISK MANAGEMENT PREMIUM CREDITS

Insured dentists who participate in risk management activities approved by the Company are eligible for the following premium credits.

A. <u>Individual Risk Management Activities</u>: Individual dentist insureds shall receive premium credits as indicated for completion, within the 12 months prior to the effective date of the policy being rated, of the following activities:

Activity	<u>Credit</u>
A Company-produced online Loss Prevention seminar.	2.5%
Company-produced Supplemental Online Modules (up to four).	0.5% premium credit for every 30 minutes of online coursework (up to a maximum of 2.0%)

- B. Any risk management credit will be revoked or withheld for any of the following reasons:
  - 1. Failure by an individual insured to certify adherence to risk management guidelines adopted by the Company and in effect at the time of application;
  - 2. Demonstrable evidence which indicates that the insured has been or is practicing in violation of guidelines or underwriting criteria adopted by the Company;
  - 3. Results of an underwriting audit which show serious deficiencies, including but not limited to non-compliance with specialty risk management guidelines; or
  - 4. Evidence of falsification of attendance, credit or completion of risk management activities applied towards a risk management credit.

Information obtained in the process of handling a claim will be used in evaluating an insured with respect to the above condition; however, the filing of a claim or incurring any expense or indemnity on behalf of an insured shall not alone be considered grounds for reducing, revoking or withholding a credit.

6. Section 4, Additional Practice Charges, is amended by adding the following

#### VII. Dental Board Examination Coverage

Dental students taking their licensing examinations will be offered occurrence coverage for their exposure while taking a dental licensing board examination. Coverage will be provided at limits of \$1,000,000 per incident, \$3,000,000 aggregate. The policy definition of Professional Health Care Services referred to in the policy is limited to only those services rendered by the insured during a dental board examination.

A \$15 charge per examinee will be charged to cover the exposure for these dental candidates. In addition, if the examinee obtains professional liability coverage with the Company after obtaining his/her license to practice dentistry, the Company will apply this fee as a reduction to the insured's first-year premium. The dentist's first professional policy to insure his/her full-time dental practice must be purchased from the Company in order to receive that \$15 reduction.

In order to recognize these and other factors affecting a particular practitioner or group practice, the Company proposes to apply a debit or credit to the otherwise applicable rate dependent upon the underwriter's overall evaluation of the risk.

The maximum credit will be 25%; the maximum debit will be 25%.

The Scheduled Rating Plan will apply to individuals as well as groups of two or more dentists as the Company becomes aware of variability in the risk characteristics of the individual or group.

\* NOTE: No credit will be given for #11, #12 or #13 above.

#### IV. DEDUCTIBLES

Deductibles are available to dentists only and may apply either to indemnity only, to indemnity <u>and</u> allocated loss adjustment expenses (ALAE), or to indemnity and ALAE and supplemental payments. Any discount will apply only to the primary limit premium layer (\$1M/\$3M). Deductibles are subject to approval by the company based on financial statements to be submitted by the insured and financial guarantees as required. The company reserves the right to require acceptable securitization in the amount of the per claim or per incident and/or aggregate deductible amount from any insured covered by a policy to which a deductible is attached.

#### A. Individual Deductibles

#### Discount as a Percentage of Rate for Applicable Primary Limit

These per incident and aggregate (if any) deductibles apply to each insured separately.

INDEMNIT			AND ALAE Per Incident
\$ 1,000	2.4%	\$ 1,000	3.0%
\$ 2,000	4.8%	\$ 2,000	6.1%
\$ 5,000	8.5%	\$ 5,000	10.6%
\$10,000	10.9%	\$10,000	13.6%
\$25,000	16.9%	\$25,000	21.20%
\$50,000	21.8%	\$50,000	27.2%
\$75,000	27.8%	\$75,000	34.8%
\$100,000	33.9%	\$100,000	42.4%
\$150,000	41.1%	\$150,000	51.4%
\$250,000	48.4%	\$250,000	60.5%
\$400,000	53.2%	\$400,000	66.6%
\$500,000	60.5%	\$500,000	75.60%

SERFF Tracking Number: PCWA-127383456 State: Illinois

Filing Company: ProAssurance Wisconsin Insurance Company State Tracking Number: PCWA-127383456

Company Tracking Number: IL-DPL-012012-RR

TOI: 11.0 Medical Malpractice - Claims Sub-TOI: 11.0007 Dentists - Oral Surgeons

Made/Occurrence

Product Name: Health Care Professional Liability Rates and Rules Manual

Project Name/Number: Rate/Rule Filing and New PRA Format/

## **Supporting Document Schedules**

Item Status: Status

Date:

Satisfied - Item: Explanatory Memorandum

Comments: Attachment:

Illinois Dental 1\_1\_12.pdf

Item Status: Status

Date:

Satisfied - Item: Form RF3 - (Summary Sheet)

Comments: Attachment:

RF-3 for PRAW dental filing eff 1-1-12.pdf

Item Status: Status

Date:

Satisfied - Item: Certification

Comments:
Attachment:
Certification.pdf

Item Status: Status

Date:

Satisfied - Item: Manual

Comments:

Attachment:

Illinois Dental Manual eff 1-1-12.PDF

Item Status: Status

Date:

Satisfied - Item: Response to 9/20/2011 objections

SERFF Tracking Number: PCWA-127383456 State: Illinois

Filing Company: ProAssurance Wisconsin Insurance Company State Tracking Number: PCWA-127383456

Company Tracking Number: IL-DPL-012012-RR

TOI: 11.0 Medical Malpractice - Claims Sub-TOI: 11.0007 Dentists - Oral Surgeons

Made/Occurrence

Product Name: Health Care Professional Liability Rates and Rules Manual

Project Name/Number: Rate/Rule Filing and New PRA Format/

Comments:

**Attachment:** 

response to 9-20-11 objections.PDF

Item Status: Status

Date:

Satisfied - Item: PRA Wis 11/3/2011 letter to

Pinnacle

Comments:

Attachment:

PRA Wis 11-3-11 letter to Pinnacle.PDF

# Section 754.EXHIBIT A Summary Sheet (Form RF-3)

# FORM (RF-3)

# SUMMARY SHEET

Change in Company's	premium or rate level produced by i	rate revision
effective 01/01/2012		

(1)	(2) Annual Premium Volume (Illinois) *	(3) Percent Change (+or-) **
	volume (minois)	Change (101-)
•		
Commercial		
Automobile Physical Damag		
Private Passenger		•
Commercial		
• •		
		#104 (1000) 194 (1000)
•		
•	***************************************	
	<b>*************************************</b>	
	***************************************	
•	\$1.008.719	+17.50%
Life of Insurance	The same of the sa	
Classes? If so,	,	
Organization, specify		•
,		
**Change in Company's premi	· ·	t from application of new
rates.	ProAssurance Wise	consin Insurance Company
		ne of Company
		Compliance Analyst
	Automobile Liability Private Passenger Commercial Automobile Physical Damag Private Passenger Commercial Liability Other Than Auto Burglary and Theft Glass Fidelity Surety Boiler and Machinery Fire Extended Coverage Inland Marine Homeowners Commercial Multi-Peril Crop Hail Other Dentist's Prof Liability Life of Insurance  Does filing only apply to certai Classes? If so, specify: This app  Brief description of filing. (If fil Organization): create a new specialty for dentist us discounts, offer first aid and corporal *Adjusted to reflect all prior rat	Automobile Liability Private Passenger Commercial Automobile Physical Damag Private Passenger Commercial Liability Other Than Auto Burglary and Theft Glass Fidelity Surety Boiler and Machinery Fire Extended Coverage Inland Marine Homeowners Commercial Multi-Peril Crop Hail Other Dentist's Prof Liability Life of Insurance  Does filing only apply to certain territory (territories) or Classes? If so, specify:  This applies to all Dentists and Oral S  Brief description of filing. (If filing follows rates of an act Organization, specify organization): We are proposing to in create a new specialty for dentist using cosmetic Botox, revise the discounts, offer first aid and corporate coverages. *Adjusted to reflect all prior rate changes. **Change in Company's premium level which will result rates.  ProAssurance Wisconstruction  ProAssurance Wisconstruction  ProAssurance Wisconstruction  Nar

Official - Title

# ILLINOIS CERTIFICATION FOR MEDICAL MALPRACTICE RATES

(215 ILCS 5/155.18)(3) states that medical liability rates shall be certified in such filing by an officer of the company and a qualified actuary that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience.

- I, Kathryn A. Neville, a duly authorized officer of ProAssurance Wisconsin Insurance Company, am authorized to certify on behalf of the Company making this filing that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience, and that I am knowledgeable of the laws, regulations and bulletins applicable to the policy rates that are the subject of this filing. I also certify that all changes made were disclosed, no written statement that the insurer, in offering, administering, or applying the filed rate/rule manual and/or any amended provisions, does not unfairly discriminate.
- I, Howard H. Friedman, a duly authorized actuary of ProAssurance Wisconsin Insurance Company, am authorized to certify on behalf of the Company making this filing that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience, and that I am knowledgeable of the laws, regulations and bulletins applicable to the policy rates that are the subject of this filing.

Kathryn A. Neville, Secretary	8-24-11
Signature and Title of Authorized Insurance Company Officer	Date
Signature and Title of Addiorized Insurance Company Officer	Date
CHE CONTRACTOR OF THE CONTRACT	8/24/4
Howard H. Friedman, ACAS, MAAA, Senior Vice President	
Signature, Title and Designation of Authorized Actuary	Date
·	
Insurance Company FEIN 39-1567580 Filing Number	L-DPL-012012-RR
Insurer's Address 100 Brookwood Place	
City Birmingham State Alabama Zip C	ode 35209
Contact Person's:	
-Name and E-mail LaQuita B. Goodwin, Compliance Specialist – Igoodwin@p	roassurance.com
-Direct Telephone and Fax Number (205) 877-4426 – Fax (205) 41	



# PROASSURANCE WISCONSIN INSURANCE COMPANY HEALTH CARE PROFESSIONALS UNDERWRITING RULES AND RATES

# **ILLINOIS MANUAL**

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# **SECTION 1**

**INTRODUCTION** 

#### INTRODUCTION

This manual contains the classifications and rates governing the underwriting of Dentists and Allied Health Professionals' Professional Liability Insurance by ProAssurance Wisconsin Insurance Company, hereinafter referred to as "the Company."

#### I. RATES AND PREMIUM CALCULATIONS

- Rates apply on a per incident and annual aggregate basis. The rates for the premium classifications selected by the Company or any special situations not delineated herein are those described in the Professional Liability State Rates and Exceptions Section of this manual, with a minimum premium being \$500 (\$250 first and second-year claims-made coverage and for Allied Health Professionals). If an individual's practice involves two or more rating territories or rating classifications, the highest rating territory or classification applies. Endorsements adding risks/exposures mid-term will be rated in accordance with the Rates and Rules in effect as of the Subject to Section 2., V, (Rate Adjustments for Changes in endorsement effective date. Exposure) of this manual, Reporting Endorsements will be rated in accordance with the Rates and Rules in effect as of the endorsement effective date. Subject to Section 2, V, (Rate Adjustments for Changes in Exposure) of this manual, endorsements effecting changes on risks/exposures currently insured will be rated using the Rules (e.g., rating classification, limits of liability and rating territory) in effect on the date of the change combined with the rates in effect on the later date of either i) the policy term effective date or ii) risk effective date.
- B. Refer to the Company for: Agents should refer to the Company any risk meeting one of the following criteria: a) Any risk or exposure for which there is no manual rate or applicable classification, or b) Risks developing annualized premium of \$100,000 or more for basic limits for individual (a) rating.
- C. <u>Non-Standard Risks</u>: Individuals rejected for standard coverage by the Company may be individually considered for coverage at an additional premium charge or other applicable coverage conditions and limitations on an individually agreed, consent-to-rate basis.
- D. Whole Dollar Premium Rule: The premiums appearing in the State Rates and Exceptions Section of this manual have been rounded to the nearest whole dollar. This procedure shall also apply to all interim premium adjustments, including endorsements or cancellations. A premium involving \$.50 or over, shall be rounded to the next higher whole dollar.
- E. <u>Net of Commission Rule</u>: In the event an agent chooses to forgo all commission and work on a fee basis, rating may be computed by reducing the base rate by the commission percentage that was otherwise payable.

#### II. CANCELLATIONS

Cancellations shall be made only within the parameters established by the State of policy issuance as framed in the Cancellation provisions of the policy including any State-specific endorsement thereto.

- A. By the Company: The earned premium shall be determined on a "pro rata" basis.
- B. <u>By the Insured</u>: The earned premium may be determined on a "short rate" basis if the entire policy is cancelled. Pro-rata calculation shall be used if a portion of the coverages or risks are cancelled but other portions of the policy remains in force. "Short rate" calculation means that total earned premium shall equal actual earned premium as of the date of cancellation plus a short rate penalty equal to ten percent (10%) of unearned premium for the remainder of the policy period.
- C. <u>Removal from the State</u>: Subject to state provisions, the policy may be canceled by the Company after the insured no longer maintains at least 75% of his dental practice within the state of issuance, regardless of whether notice has been given by the insured.

#### **SECTION 2**

CLASSIFICATION AND/OR RATING MODIFICATIONS AND PROCEDURES

#### **CLASSIFICATION AND/OR RATING MODIFICATIONS AND PROCEDURES**

#### I. PART-TIME AND SEMI-RETIRED PROFESSIONALS

The Part-Time Discount is available to dentists:

- A. who have at least 15 years of postgraduate clinical practice experience and are scaling back their practice in anticipation of retirement; or
- B. who practice less than 20 hours per week due to family needs (caring for young children and/or ill or disabled family members); or
- C. who are required to practice on a reduced basis as a result of a physical or medical condition, with the company's approval; or
- D. who practice at least 30 hours per week at a hospital, community health center or other health care facility where medical professional liability insurance is provided by the facility. A certificate of insurance listing the Company as certificate holder must be presented annually for the credit to apply.

Insureds eligible for the New Dentist Discount are not eligible for the Part-Time Discount. Also, dentists employing or supervising paramedicals (as listed in Section V, Item I) are not eligible for the Part-Time Discount.

This discount is intended to more accurately rate the insured who practices his specialty on a limited basis. The available discounts are:

		Average Weekly Practice
<b>TYPE</b>	<u>Class</u>	Hours < 20 hours
Dentist	1A to 5	50%
All other		None

<sup>\*</sup> Dentists whose average weekly practice hours are less than 12 hours will be individually evaluated by the company.

Practice hours are defined as:

- hospital rounds,
- charting and patient planning,
- on call hours involving patient contact, whether direct or by telephone,
- consultation with other dentists, and
- patient visits/consultations.

Practice hours of dentists receiving the Part-Time Discount are subject to random audit by the Company.

#### II. LOCUM TENENS

Coverage for temporary substitute health care providers may be provided through the issuance of an Additional Insured endorsement or the Locum Tenens Endorsement. In states not requiring a separate set of limits for the substitute, the Locum Tenens health care providers will be added to the insured's policy as an additional insured, sharing in the insured health care provider's limits. In states requiring separate limits for each health care provider, a Locum Tenens endorsement will be added to the insured health care provider's policy, providing a separate set of temporary limits to the Locum Tenens. Locum tenens coverage should not exceed a period of 90 days.

To cover the processing and administrative costs involved, a \$50 minimum premium charge per Locum Tenens endorsement may be applied. At underwriter's discretion, the processing charge may be waived. The locum tenens dentist must submit an application for Company approval in advance of the requested effective date of coverage.

#### III. CORPORATE LIABILITY - SHARED LIMIT

Where allowed by law, no charge will be made for entities sharing in the available limits of liability of the insured dentists or other insured organizations, providing each member is insured by the Company and the risk is otherwise acceptable.

#### IV. FULL-TIME EQUIVALENT RATING

Rating of certain multi-dentist groups may, at the Company's option, be determined on a full-time equivalent (FTE) unit basis. Under this rating method, policies may be issued to positions with individuals who may fill such positions identified rather than being issued to specific individuals. An FTE rate will be determined based upon the filed and approved rate for a given classification of dentists but will be allocated based upon either the number of average hours of practice for a given specialty or the average number of patient contacts/visits in a 12 month period.

All FTE rated applications shall be referred to the Company.

# V. RATE ADJUSTMENTS FOR CHANGES IN EXPOSURE -- CLAIMS-MADE, RETROACTIVE, AND REPORTING ENDORSEMENT COVERAGE

#### A. Claims-Made Coverage

The calculations for changes in exposure are performed by taking the difference between claims-made rates for each period of differing exposures. These calculations are appropriate for changes in practice specialty, changes in rating territory or practice in other states, changes between part-time and full-time practice, and other changes that would affect a calculated rate. Currently approved rates, classification tables and discount or surcharge factors for the appropriate state(s) are used. This method can be generalized by using the following formula to calculate a rate for the upcoming year.

- 1. Rate for current practice, determined using a retroactive date equal to the date that the *current* practice patterns began,
- 2. plus rate for prior practice, determined using a retroactive date equal to the date that the *previous* practice patterns began,
- 3. less rate for prior practice, determined using a retroactive date equal to the date that the *current* practice patterns began.

This method is applied in a similar manner if more than one practice change occurred during the previous four years, and the components are pro-rated if the change occurred at a date other than the policy anniversary date.

For example, if a dentist had practiced general dentistry with cosmetic Botox for many years, then stopped practicing cosmetic Botox and began to practice general dentistry-no surgery only, the appropriate premium for the upcoming policy period would be:

General dentist-No surgery rate for claims-made year one, plus General dentists, Cosmetic Botox rate for claims-made year five, less General dentists, Cosmetic Botox rate for claims-made year one.

This produces a blended rate, reflecting the remaining General dentists, Cosmetic Botox exposure that makes up the majority of the expected reported claims in the upcoming year, plus the initial General dentist-No surgery exposure.

The rate for the second year of gynecology-only practice would be:

General dentist-No surgery rate for claims-made year two, plus General dentists, Cosmetic Botox rate for claims-made year five, less General dentists, Cosmetic Botox rate for claims-made year two.

This adjustment process continues for two more years, until the beginning of the fifth year in the new specialty. At that time, the blended rate would be:

General dentist-No surgery rate for claims-made year five, plus General dentists, Cosmetic Botox rate for claims-made year five, less General dentists, Cosmetic Botox rate for claims-made year five, which is simply equal to the General dentist-No surgery rate for claims-made year five.

Although this method of adjusting rates is designed to accommodate most situations, changes in dental practice often result from increasing or decreasing patient loads, additional dental training, relocation of the practice, gradual reduction in practice nearing retirement and other underwriting factors which affect the risk of loss. As a result, the Company may choose to waive the exposure change adjustment process in specific situations, thereby utilizing the current rating variables without modification. Conversely, a debit under the Scheduled Rating Plan may be applied at the underwriter's discretion, based on more than five years of practice in specialties with long claim emergence patterns.

#### B. Prior Acts Coverage

When prior acts coverage is provided, the same method is utilized, as if the insured had been with the Company during the prior acts period. Practice information regarding the prior acts period is obtained from the insurance application.

#### C. Reporting Endorsement Coverage

If reporting endorsement coverage is to be rated, the same method is utilized, substituting the reporting endorsement rates for the claims-made rates. For example, a reporting endorsement purchased at the end of the second year of general dentist-no surgery practice in the general dentists, cosmetic Botox example described above would be:

general dentist-no surgery reporting endorsement premium for claims-made year two, plus general dentists, cosmetic Botox reporting endorsement premium for claims-made year five, less general dentists, cosmetic Botox reporting endorsement premium for claims-made year two.

#### D. Occurrence Coverage

The calculations for changes in exposure are performed by prorating the rates for the periods of differing exposures. These calculations are appropriate for changes in practice specialty, changes in rating territory or practice in other states, changes between part-time and full-time practice, and other changes that would affect a calculated rate. Currently approved rates, classification tables and discount or surcharge factors for the appropriate state(s) are used.

Although this method of adjusting rates is designed to accommodate most situations, changes in dental practice often result from increasing or decreasing patient loads, additional dental training, relocation of the practice, gradual reduction in practice nearing retirement and other underwriting factors which affect the risk of loss. As a result, the Company may choose to waive the exposure change adjustment process in specific situations, thereby utilizing the current rating variables without modification. Conversely, a debit under the Scheduled Rating Plan may be applied at the underwriter's discretion, based on more than five years of practice in specialties with long claim emergence patterns, such as Pediatrics or Obstetrics.

#### VI. REPORTING ENDORSEMENTS (Claims-made only)

#### A. Reporting Endorsement Premium Calculation

With respect to calculation of Reporting Endorsement premium, all credits/discounts, with the exception of the New Doctor or Dentist Discount, and all debit/surcharges will apply to Reporting Endorsement premium calculations. With respect to risks or exposures written on a consent-to-rate basis, (a) rated basis or Full-Time Equivalent Rating basis at the time the Reporting Endorsement is issued, Reporting Endorsement premium will be calculated on that same basis. If the policy is terminated during the first year, pro-rate the tail premium. For terminations during the second, third or fourth claims-made policy year, blend the applicable tail factors. The Company may refuse to offer deductible options for premium credit on reporting endorsements in the case of insufficient securitization.

#### B. Waiver of Reporting Endorsement Premium

The premium for the reporting endorsement may be waived as provided by the contract in force or at the discretion of the Company.

## SECTION 3 PROFESSIONAL LIABILITY DISCOUNTS

#### PROFESSIONAL LIABILITY DISCOUNTS

#### I. MAXIMUM CREDIT

Maximum credit available per insured will be limited to 25% except for the following:

- Deductibles/Self-Insured Retentions.
- Risks developing \$100,000 or more annualized premium.

#### II. NEW DENTIST DISCOUNT

This discount will apply only to solo practicing dentists who have never been in practice and proceed directly into practice from training, or dentists who fit within that category except for an interim period of employment not to exceed two years. Dentists who would otherwise qualify but who are joining an established group practice insured by the Company where their clinical exposure will not exceed 30 hours per week credited as if they have had one additional year of practice. This discount will also apply only to dentists who proceed directly into practice from training, or dentists who fit within the category except for an interim period of employment not to exceed two years.

Year of Coverage	<b>Annual Premium Discount per Policy</b>
Since Training	<u>Dentists</u>
Year 1	60%
Year 2	40%
Year 3	0%

Note that these discounts do not apply to occurrence or extended reporting endorsement rates.

#### III. SCHEDULED RATING PROGRAM

The Company has determined that significant variability exists in the hazards faced by dentists engaged in the practice of dentistry. Exposure conditions vary with respect to:

- 1. Number of years experience in dentistry;
- 2. Number of patient exposures;
- 3. Organization (if any) and size;
- 4. Dental standards review and claims review committees;
- 5. Other risk management practices and procedures;
- 6. Training, accreditation and credentialing;
- 7. Continuing Dental Education activities;
- 8. Professional liability claim experience;
- 9. Record-keeping practices;
- 10. Maintenance and utilization of certain monitoring equipment, diagnostic tests or diagnostic procedures;
- 11. Participation in capitation contracts; and\*
- 12. Insured group maintains differing limits of liability on members.\*
- 13. Services provided at correctional facilities, nursing homes or mobile dental units.

In order to recognize these and other factors affecting a particular practitioner or group practice, the Company proposes to apply a debit or credit to the otherwise applicable rate dependent upon the underwriter's overall evaluation of the risk.

The maximum credit will be 25%; the maximum debit will be 25%.

The Scheduled Rating Plan will apply to individuals as well as groups of two or more dentists as the Company becomes aware of variability in the risk characteristics of the individual or group. At the underwriter's discretion, objective credits otherwise applicable to an insured will not be applied in situations where a scheduled debit is deemed necessary.

\* NOTE: No credit will be given for #11, #12 or #13 above.

#### IV. DEDUCTIBLES

Deductibles are available to dentists only and may apply either to indemnity only, to indemnity <u>and</u> allocated loss adjustment expenses (ALAE), or to indemnity and ALAE and supplemental payments. Any discount will apply only to the primary limit premium layer (\$1M/\$3M). Deductibles are subject to approval by the company based on financial statements to be submitted by the insured and financial guarantees as required. The company reserves the right to require acceptable securitization in the amount of the per claim or per incident and/or aggregate deductible amount from any insured covered by a policy to which a deductible is attached.

#### A. Individual Deductibles

## Discount as a Percentage of Rate for Applicable Primary Limit

These per incident and aggregate (if any) deductibles apply to each insured separately.

INDEMNITY ONLY  Deductible Per Incident	INDEMNITY AND ALAE <u>Deductible Per Incident</u>
\$ 1,000 2.4% \$ 2,000 4.8% \$ 5,000 8.5% \$10,000 10.9% \$25,000 16.9% \$50,000 21.8% \$75,000 27.8% \$100,000 33.9% \$150,000 41.1% \$250,000 48.4% \$400,000 53.2%	\$ 1,000 3.0% \$ 2,000 6.1% \$ 5,000 10.6% \$10,000 13.6% \$25,000 21.20% \$50,000 27.2% \$75,000 34.8% \$100,000 42.4% \$150,000 51.4% \$250,000 60.5% \$400,000 66.6%
\$500,000 60.5%	\$500,000 75.60%
Per Incident/Aggregate	Per Incident/Aggregate
\$ 1,000/ 3,000 2.2% \$ 2,000/ 6,000 4.4% \$ 5,000/15,000 7.7% \$10,000/30,000 9.9% \$25,000/75,000 15.4% \$50,000/150,000 19.8% \$75,000/225,000 25.3% \$100,000/300,000 30.8% \$150,000/450,000 37.4% \$250,000/750,000 44.0% \$400,000/1,200,000 48.4%	\$ 1,000/ 3,000 2.8% \$ 2,000/ 6,000 5.5% \$ 5,000/15,000 9.6% \$10,000/30,000 12.4% \$25,000/75,000 19.3% \$50,000/150,000 24.8% \$75,000/225,000 31.6% \$100,000/300,000 38.5% \$150,000/450,000 46.8% \$250,000/750,000 55.0% \$250,000/750,000 60.5%
\$500,000/1,500,000 55.0%	\$250,000/750,000 68.8%

For deductible to apply per certificate holder, apply a factor of 1.100 to the appropriate deductible factor. For other deductible amounts selected by policyholders, refer to management for rating.

## B. Group Deductibles

Indemnity Deductible

An optional deductible which limits the amount the entire group will have to pay, if multiple claims are made in a policy year, is available. Under this program, the per incident deductible continues to apply separately to each insured involved in a suit. However, the aggregate deductible applies to all insureds in the group combined thereby reducing the organization's maximum potential liability in a policy year.

When an organization is insured with a separate limit of coverage, the organization is counted when totaling the number of insureds below.

Group aggregate deductible discounts apply to \$1M/\$3M premiums only. The applicable Deductible Discount will not change during the policy term despite changes in the number of insureds, but will be limited by any applicable maximum credit amount.

indemnity Deductible					
Per Incident/Aggregat	e	Number	of Insur	<u>eds</u>	Maximum
(\$000)	<u>2 - 19</u>	<u>20 - 40</u>	<u>41 - 60</u>	<u>61 - 100</u>	Credit
5/15	.073	.066	.055	.044	\$ 12,750
10/30	.096	.089	.076	.061	25,500
25/75	.152	.143	.127	.105	63,750
50/150	.205	.197	.180	.154	127,500
100/300	.300	.293	.277	.252	255,000
250/750	.424	.424	.419	.405	637,500
Indemnity & ALAE					
Deductible					
Per Incident/Aggregat	e	Number	of Insur	<u>eds</u>	Maximum
(\$000)	<u>2 - 19</u>	<u>20 - 40</u>	<u>41 - 60</u>	<u>61 - 100</u>	Credit
5/15	.093	.083	.067	.055	\$ 12,750
10/30	.120	.111	.095	.076	25,500
25/75	.191	.180	.159	.132	63,750
50/150	.256	.246	.224	.193	127,500
100/300	.375	.366	.347	.314	255,000
250/750	.530	.530	.524	.506	637,500

#### C. Mandatory Deductibles

The deductible mechanism may be applicable when a policyholder exhibits a pattern of claim frequency that exceeds the average for his/her specialty. In the consideration of a deductible assessment, severity is usually not an issue.

Deductibles may be imposed in amounts from \$1,000 to \$250,000 per claim. There is no corresponding premium discount, and there are no aggregate limits on mandatory deductibles.

An amendatory deductible endorsement will be added to the policy at renewal and will be maintained for no less than one year. The policy will be subject to an annual review thereafter for consideration of a revised sanction.

## V. GENERAL RULES

- A. Discounts will only be applied to qualifying insureds at the initial issuance of such policy or at the next renewal date.
- B. Discounts will apply in the following order:
  - 1. Deductible Discount (primary premium only).
  - 2. All other discounts.
- C. Additional practice charges will be applied to the premium after all discounts have been applied.
- D. Corporate Liability premium will be determined after all discounts and surcharges have been applied.

## **SECTION 4**

ADDITIONAL PRACTICE CHARGES

## ADDITIONAL PRACTICE CHARGES

# I. DENTAL SERVICES PROVIDED IN A STATE OUTSIDE THE STATE OF POLICY ISSUANCE

Insureds engaging in the routine care and treatment of patients outside the state in which the policy is issued may be subject to appropriate surcharge or credit based upon rates consistent with those charged for a like risk in said state.

#### II. PARTNERSHIP - CORPORATION - PROFESSIONAL ASSOCIATION COVERAGE

Coverage for partnerships, corporations, or professional associations may be written with a separate limit of liability. The premium charge will be a percentage (selected from the table below) of the sum of each member dentist's net individual premium. The minimum premium charge for this coverage is \$100 for dental. However, this minimum premium may be waived for a specific market or program applying to eligible members of an association. For each member dentist not individually insured by the Company, a premium charge will be made equal to 30% of the appropriate specialty rate if the Company agrees to provide such coverage. In order for the entity to be eligible for coverage under the separate policy, the Company must insure all member dentists, or at least 60% of the dentist members must be insured by the Company and the remaining dentists must be insured by another professional liability program acceptable to the Company.

# of Insureds	\$1M/\$3M Charge	\$500K/\$1.5M	\$250K/\$750K
1	N/A	N/A	N/A
2-5	10.0%	18.0%	23.0%
6 – 9	10.0%	17.0%	21.0%
10 – 19	9.0%	13.0%	17.0%
20 – 49	7.0%	9.0%	13.0%
50 or more	5.0%	7.5%	10.0%

# III. PARTNERSHIP-CORPORATION-PROFESSIONAL ASSOCIATION EXTENDED REPORTING ENDORSEMENT COVERAGE

Partnerships, corporations, or professional associations that purchase a separate limit of liability may be eligible to purchase an Extended Reporting Endorsement upon cancellation of the coverage. The premium charge for the entity extended reporting endorsement will be a percentage of the sum of each member dentist's net individual reporting endorsement premium, based on the number of insureds and the table in Paragraph II, above.

#### IV. CLAIMS FREE CREDIT PROGRAM

A dentist will be considered claims free for purposes of this credit program if:

- 1. no loss payment has been made during the Evaluation Period, and
- 2. the total of allocated loss adjustment expense [ALAE] payments made during the Evaluation Period plus any Company established reserves for loss or ALAE does not exceed \$35,000.

Only claims reported during the Evaluation Period shall be included in measuring the payment and reserve criteria stated above. The Evaluation Period is based upon the dentist's rating class as defined in the table below and shall end on the effective date of the policy period to be rated. The Evaluation Period shall begin no earlier than the time when the dentist first begins the practice of dentistry following formal training (residency or a continuous period of residency and fellowship). The Company will review the claims history of each insured or applicant for the purpose of evaluating the applicability of each claim based upon the facts and circumstances of specific claims. Reported incidents that do not involve a demand for damages by a third party will not be included in the evaluation.

Dentist Class Evaluation Period

1A - 5 10 Yrs.

The claims free dentist will receive a 3% credit for compliance with the minimum Claims Free Period and will earn an additional 1% credit for each continuous claims free year thereafter up to 15% in total. However, if the dentist has been continuously insured by the Company for 10 or more years, the maximum allowable Claims Free Credit that can be earned will be increased to 20%.

Credits will be applied or removed at policy inception or renewal only. Inclusion of claims history with prior carriers is subject to presentation of information acceptable to the Company. The determination of claims to be included and payment or reserve amounts to be considered will be based upon information available at the time the policy is rated, typically 60 days prior to effective date.

Dentists will be treated as "Class 1" for determination of their Evaluation Period and will be eligible for a maximum Claims Free Credit of 15%, in accordance with the earning schedule above. However, the Claims Free Dentist must have no incurred losses or ALAE (payments or reserves) during the Evaluation Period. Notwithstanding any other provisions of this section, no dentist with 2 or more reported claims will be eligible for a claims free credit without management approval.

## V. LEGAL DEFENSE COVERAGE

The Company offers the Professional Legal Defense Extended Coverage to insured dentists at no charge.

Limits of Liability will be offered as follows:

# of insureds	"Each Covered Inv	vestigation" "Each Policy Period"
1 - 5	\$25,000	\$25,000 X (# of insureds
6 - 10	\$25,000	\$125,000
11 - 20	\$25,000	\$175,000
21 +	\$25,000	\$225,000

The limit of liability for "covered audits" will be \$5,000 per covered insured with a deductible of \$1,000 per audit per insured.

## **SECTION 5**

PHYSICIAN EXTENDER, PARAMEDICAL AND ALLIED HEALTH PROFESSIONAL LIABILITY RATING

## I. PHYSICIAN EXTENDER, PARAMEDICAL, ALLIED HEALTH EMPLOYEE PROFESSIONAL LIABILITY

Professional employees (other than dentists, certified registered nurse anesthetists, nurse practitioners, physicians, physicians' assistants, surgeons, surgeons' assistants, advanced practice nurse prescribers) are automatically included, at no additional charge, as additional insureds under policies issued to their employers. The limits of liability are on a shared basis with the employer.

The following paramedical employees may be individually covered by the Company by payment of an additional premium or covered elsewhere through a program deemed acceptable to the Company with minimum limits of liability equal to or greater than those of the insured employer. Coverage is available on a shared-limits basis or with separate individual limits. To determine the additional premium for the coverage selected, apply the appropriate factor from the premium assigned to dentist Class Code 80211, as specified, for the applicable claims-made year and limits of liability:

(Paramedical employees written on a shared-limits basis will be charged a fourth year claims-made premium regardless of retroactive date and the shared-limits factors stated above will always be applied to a fourth year claims-made premium.)

	(Factors based on 80211)			
Employee	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor	
Physician Assistant (PA)	0.1684	0.765	0.1473	
Surgeon's Assistant (SA)	0.1684	0.765	0.1473	
Certified Nurse Practitioner (CNP)	0.1684	0.765	0.1473	
Advanced Practice Nurse Prescriber (APNP)	0.1684	0.765	0.1473	

	(Factors based on 80211)			
Employee	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor	
Certified Nurse Anesthetist (CRNA) – not part of an insured group	N/A	1.540	0.186	
CRNA employed by an insured group - separate limits basis	N/A	1.025	0.133	
CRNA employed by an insured group – shared limits basis with ratio of CRNAs to anesthesiologists between 2:1 and 4:1	N/A	N/A	N/A	
CRNA employed by an insured group – shared limits basis with ratio of CRNAs to anesthesiologists no more than 2:1	N/A	N/A	N/A	

**NOTE**: When the limits of liability apply on a shared basis with the dentists of the group, the premium charge for the excess limits for the paramedical employees will be calculated at the level that the majority of dentists carry.

## II. ALLIED HEALTH PROFESSIONAL EMPLOYEES

Certain Allied Health professionals are eligible for separate insurance by the Company at individual limits of liability. The premium charge will be determined by applying the factors below to the appropriate rate for the designated Dentist Class Code in the applicable rating territory.

## **STEP-RATING FACTORS**

First Year	50% of mature premium
Second Year	80% of mature premium
Third Year	100% of mature premium

SPECIALTY	CLASS CODE	\$1M/\$3M
		(Factors based on 80211)
Physician Assistant	80116	0.765
Surgeon Assistant	80116(B)	0.765
Certified Registered Nurse Anesthetist	80960	1.540
Dental Assistant	80207	0.018
Dental Hygienist	80208	0.018

At the discretion of the underwriter, additional insured status may be granted to the non-insured allied health entity for a 10% additional charge. The entity will share in the limits of liability of the insured allied health provider but only for the activities of such provider but only for the activities of such provider.

Mature premiums under \$500 are not eligible for the step-rating factors.

## Reporting Endorsements:

Reporting Endorsements are available to Allied Health Professionals insured under separate policies by application of the factors below.

Prior Year Claims-Made	<u>Factors</u>
1	1.00
2	1.25
3+	1.50

## **SECTION 6**

DENTAL PROFESSIONAL LIABILITY SPECIALTY CODES AND DESCRIPTIONS

#### DENTAL SPECIALTY CODES & CLASSIFICATIONS

\*

## **DENTISTS - CLASS 1A**

Applies to dentists who perform dentistry on patients who have been treated with local anesthesia or by inhalation sedation and does not apply to treatment involving any general anesthesia or intravenous or intramuscular agent unless performed in a hospital.

This class does not apply to dentists performing extractions, root canals or other oral surgery or endodontic procedures. This class does not apply to oral surgeons.

#### **DENTISTS - CLASS 1**

- Applies to dentists who perform dentistry on patients who have been treated with local anesthesia or by inhalation sedation and does not apply to treatment involving any general anesthesia or intravenous or intramuscular agent unless performed in a hospital. This class does not apply to dentists performing the initial placement of dental implants. This class does not apply to oral surgeons.
- Applies to orthodontists and endodontists who perform dentistry on patients who have been treated with local anesthesia or by inhalation sedation and does not apply to treatment involving any general anesthesia or intravenous or intramuscular agent unless performed in a hospital. This class does not apply to dentists performing the initial placement of dental implants. This class does not apply to oral surgeons.
- Applies to periodontists who perform dentistry on patients who have been treated with local anesthesia or by inhalation sedation and does not apply to treatment involving any general anesthesia or intravenous or intramuscular agent unless performed in a hospital. This class does not apply to dentists performing the initial placement of dental implants. This class does not apply to oral surgeons.

#### **DENTISTS - CLASS 2**

- Applies to dentists, endodontists and periodontists as defined for Class 1 but, in addition, permits the initial placement of dental implants.
- Applies to dentists, endodontists and periodontists as defined for Class 1 but, in addition, permits dentistry on patients who have been treated by intravenous or intramuscular sedation in the office, but only if the sedation is administered by a Dental or Medical Anesthetist. If intravenous or intramuscular sedation is performed in a hospital only, Class 1 will apply. This class does not apply to oral surgeons.

#### **DENTISTS - CLASS 3**

Applies to dentists as defined for Classes 1 or 2 but, in addition, permits dentistry on patients who have been treated by intravenous or intramuscular sedation in the office, administered by the dentist or a CRNA. If intravenous or intramuscular sedation is performed in a hospital only, Class 1 or 2 will apply, as appropriate. This class does not apply to oral surgeons.

#### ORAL SURGERY - CLASS 4

Includes all oral surgeons and also applies to dentists as defined in Classes 1A through 3 who additionally perform dentistry on patients who are being treated with general anesthesia in the office.

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## **DENTISTS - CLASS 5**

Applies to dentists as defined for Classes 1 or 2 but, in addition, permits use of cosmetic Botox on patients who have been treated by intravenous or intramuscular sedation in the office, administered by the dentist or a CRNA. This class does not apply to oral surgeons.

## PARADENTAL EMPLOYEE COVERAGE

Coverage on a shared limits basis is automatically provided for professional employees of the Policyholder or an insured under the policy with no additional charge (e.g., dental assistants, dental hygienists and lab technicians).

While a dental insured's insured paradental employees are automatically covered under the policy, a premium charge for Certified Registered Nurse Anesthetists (CRNAs) will be made as indicated in Section 6, I – Employed Certified Registered Nurse Anesthetist.

## **SECTION 7**

STATE RATES AND EXCEPTIONS – DENTISTS

## I. RATES

## A. Dental Rating Classes – Illinois

The following indicates the specialty classification codes applicable to the rating classes on the following pages:

1A	80213
1	80211
	80214
	80215
2	80211(F)
	80211(G)
3	80209
4	80210
5	80211(I)

## **B.** Dentists Professional Liability Rates

## 1. Claims-Made Rates by Year

Territory 1: Cook, Lake, Monroe, St. Clair and Will counties

		\$100	,000 / \$300,000		
Class Code	1	2	3	4	5+
1A	400	565	675	780	890
1	450	660	795	915	1,040
2	450	660	795	915	1,040
3	850	1,365	1,705	1,945	2,180
4	1,915	3,250	4,140	4,680	5,220
5	4,175	7,255	9,305	10,445	11,585
		\$200	,000 / \$600,000		
Class Code	1	2	3	4	5+
1A	420	600	720	835	950
1	480	705	855	985	1,115
2	480	705	855	985	1,115
3	920	1,480	1,860	2,115	2,370
4	2,090	3,555	4,535	5,125	5,715
5	4,575	7,960	10,220	11,470	12,725
		\$500,	000 / \$1,000,000		
Class	1	2	2	4	<b>5</b> .
Code	1		3	4	5+
1A	470	690	835	960	1,090
1	540	815	995	1,145	1,290
2	540	815	995	1,145	1,290
3	1,070	1,755	2,210	2,505	2,805
4	2,485	4,260	5,445	6,145	6,850
5	5,495	9,585	12,315	13,830	15,350
		\$1,000	,000 / \$3,000,000		
Class Code	1	2	3	4	5+
				<u> </u>	
1A	515	770	940	1,080	1,220
1	600	915	1,130	1,295	1,460
2	600	915	1,130	1,295	1,460
3	1,215	2,010	2,540	2,885	3,225
4	2,865	4,935	6,310	7,125	7,935
5	6,370	11,140	14,320	16,090	17,855
100 07 11	- ,	Effective January 1,		,	Page 2

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## 1. Claims-Made Rates by Year (cont.)

Territory 2: Remainder of State

		\$100	,000 / \$300,000		
Class Code	1	2	3	4	5+
1A 1	350 390	475 550	560 655	655 760	745 865
2 3 4 5	390 700 1,515 3,255	550 1,095 2,540 5,625	655 1,355 3,225 7,200	760 1,550 3,655 8,080	865 1,740 4,080 8,955
J	3,233		,000 / \$600,000	0,000	0,755
Class Code	1	2	3	4	5+
1A 1 2 3	365 410 410 750	505 585 585 1,185	600 700 700 1,475	695 810 810 1,680	795 925 925 1,885
4 5	1,650 3,565	2,780 6,165	3,530 7,905	3,995 8,870	4,460 9,835
Class Code	1	2	3	4	5+
1A 1 2 3 4 5	405 460 460 865 1,955 4,270	570 670 670 1,390 3,320 7,415	685 810 810 1,740 4,230 9,515	795 935 935 1,980 4,780 10,685	900 1,055 1,055 2,225 5,335 11,850
Class	\$1,000,000 / \$3,000,000				
Code	<u> </u>		3	4	5+
1A 1 2 3 4 5	440 505 505 980 2,250 4,945	635 750 750 1,590 3,840 8,615	765 910 910 2,000 4,900 11,060	885 1,050 1,050 2,270 5,535 12,420	1,005 1,185 1,185 2,545 6,170 13,780

## 2. Reporting Endorsement Rates by Year

Territory 1: Cook, Lake, Monroe, St. Clair and Will counties

		\$100,000 / \$300,000						
Class Code	1		2	3	4	5+		
1A 1		573 670	868 1,014	1,026 1,199	1,103 1,289	1,140 1,332		
2		670	1,014	1,199	1,289	1,332		
3		404	2,126	2,514	2,701	2,793		
4		362	5,090	6,019	6,468	6,687		
5	7,	461	11,295	13,358	14,354	14,840		
			\$20	00,000 / \$600,000				
Class Code	1		2	3	4	5+		
1A		612	926	1,095	1,177	1,217		
1		718	1,087	1,286	1,381	1,428		
2 3		718	1,087	1,286	1,381	1,428		
		526	2,311	2,733	2,936	3,036		
4 5		680 105	5,572	6,589	7,081	7,321		
3	8,	195	12,407	14,672	15,766	16,301		
Class			\$500	0,000 / \$1,000,000	)			
Class Code	1		2	3	4	5+		
1A	702		1,063	1,257	1,351	1,396		
1	831		1,258	1,487	1,598	1,652		
2	831		1,258	1,487	1,598	1,652		
3	1,806		2,735	3,234	3,475	3,593		
4 5	4,411 9,885		6,679 14,966	7,898 17,699	8,487 19,019	8,775 19,663		
			\$1,00	00,000 / \$3,000,00	00			
Class Code	1		2	3	4	5+		
1A		<del></del> 786	1,190	1,407	1,512	1,563		
1		940	1,424	1,683	1,809	1,870		
		940	1,424	1,683	1,809	1,870		
2 3		077	3,144	3,718	3,996	4,131		
4		110	7,737	9,149	9,831	10,165		
5	11,	499	17,409	20,587	22,122	22,872		

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## 2. Reporting Endorsement Rates by Year (cont.)

Territory 2: Remainder of State

	\$100,000 / \$300,000					
Class Code	1	2	3	4	5+	
1A	480	726	859	923	954	
1	557	843	997	1,072	1,108	
2	557	843	997	1,072	1,108	
3	1,121	1,697	2,006	2,156	2,229	
4	2,628	3,978	4,704	5,055	5,226	
5	5,767	8,731	10,325	11,095	11,471	
		\$200.	,000 / \$600,000			
Class Code	1	2	3	4	5+	
1.4			017	007	1.010	
1A	512	775	917	985	1,018	
1	596	902	1,067	1,146	1,185	
2	596	902	1,067	1,146	1,185	
3	1,214	1,838	2,173	2,336	2,415	
4 5	2,872	4,349	5,142	5,526	5,713	
3	6,334	9,589	11,340	12,186	12,599	
Class		\$500,0	000 / \$1,000,000			
Code	1	2	3	4	5+	
1A	580	878	1,038	1,115	1,153	
1	679	1,029	1,216	1,307	1,351	
2	679	1,029	1,216	1,307	1,351	
3	1,433	2,169	2,565	2,757	2,850	
4	3,436	5,202	6,151	6,610	6,834	
5	7,631	11,554	13,663	14,682	15,180	
		\$1,000,000 / \$3,000,000				
Class Code	1	2	3	4	5+	
1A	647	980	1,159	1,245	1,287	
1	763	1,155	1,366	1,468	1,518	
2	763	1,155	1,366	1,468	1,518	
3	1,639	2,481	2,934	3,153	3,260	
4	3,973	6,016	7,114	7,645	7,904	
5	8,874	13,436	15,888	17,073	17,652	
5	0,07	15,750	13,000	11,013	17,032	

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## 3. Occurrence Rates by Year

Territory 1: Cook, Lake, Monroe, St. Clair and Will counties

Class Code	100/300	200/600	500/1500	1000/3000
1A	1,015	1,090	1,260	1,425
1	1,200	1,295	1,510	1,720
2	1,200	1,295	1,510	1,720
3	2,610	2,845	3,385	3,905
4	6,370	6,980	8,385	9,730
5	14,360	15,770	19,010	22,115

Territory 2: Remainder of State

Class Code	100/300	200/600	500/1500	1000/3000
1A	840	900	1,030	1,160
1	985	1,055	1,225	1,380
2	985	1,055	1,225	1,380
3	2,070	2,250	2,665	3,065
4	4,960	5,430	6,510	7,545
5	11,105	12,190	14,685	17,070

## **4. Excess Limits Premium Factors**

Excess limits premium shall be derived by applying the appropriate factor below to the appropriate primary rate. Excess limits are only offered above underlying limits of \$1,000,000.

\$1M/\$3M Primary

<b>EXCESS</b>	Dentists/
LIMITS	Oral Surgeons
\$1M	0.0480
\$2M	0.0960
\$3M	0.1450
\$4M	0.1935
\$5M	0.2225

These factors are based upon negotiated reinsurance agreements. Deviation from these factors up to 25% based upon negotiated agreements with reinsurers and/or underwriting judgment may apply.

## II. EXCEPTIONS

## A. Policy Issuance

- 1. If the insured elects to accept the Waiver of Consent to Settle Endorsement, Form PRA-HCP-612, a credit of 7% will be applied.
- 2. The Illinois State Law Endorsement must be attached to the policy at the time of issuance.
- 3. Item III, Premium Payments, is hereby added to Section 1, Introduction, as follows:

#### III. PREMIUM PAYMENTS

- 1. Annual Payment Plan The premium must be paid in full prior to the inception date of the policy.
- 2. Semi-Annual Payment Plan -60% of the premium must be paid prior to the policy inception date and one installment of 40% is due six months after inception.
- 3. Quarterly Payment Plan -35% of the premium must be paid prior to the policy inception date, with second and third quarterly payments of 25% each and a final quarterly payment of 15%.
- 4. Nine Payment Plan 20% down and eight consecutive monthly installments of 10% each. This plan requires that the policyholder participate in the Electronic Payment Plan in which premiums are automatically deducted from the policyholder's bank account.

No finance charges or fees apply to these payment plans. The option to pay premium on other than the Annual Payment Plan may be withdrawn by the Company if the insured has failed to make premium payments when due.

#### B. Rules

1. Section 3, Professional Liability Discounts, is amended by adding the following:

## VI. BLENDING CREDIT OR DEBIT

A blending credit is available for those accounts that are rated in one territory, but have a percentage of their practice in another (one or more) territory. This credit is intended to bring the premium in line with the exposure per territory. It is not intended to reduce the premium below that of which they would pay in the outside territory. The Named Insured must provide a complete distribution of their practice. This distribution may include percentages for office and hospital practice along with a further breakdown into territory for each facet. This information must be completed in order to provide an accurate credit.

2. Section 3, Professional Liability Discounts, is amended by adding the following:

#### VII. GROUP PRACTICE MODIFICATION PLAN

Credits or debits for groups will be determined annually on the basis of our evaluation of each individual group's risk profile, which assesses such characteristics as changes in maturity, number of healthcare providers, specialty composition, management, employees, patient records, quality assurance, facilities, billing procedures and loss history.

## **Group Practice Eligibility**

- 1. a. For a group of dental healthcare providers, two or more permanently licensed, practicing dentists.
  - b. Other markets are not eligible for group practice (entity) policies or rating, unless specifically addressed in this manual.

- 2. Group must be a corporation, partnership, joint venture, or limited partnership association.
- 3. Primary location where both professional services are rendered and administrative functions (billing, patient records) are undertaken.
- 4. Satellites are acceptable to the extent they are controlled and are practicing as part of the primary location.
- 5. The entity must be organized for the purpose of delivering professional services to patients.

## **Group Practice Primary Evaluation Criteria**

- 1. Length of time entity has operated as a group.
- 2. Degree of specialization within the group.
- 3. Stability of members and locations.
- 4. Reputation and standard within the community served.
- 5. Promotional materials, advertising, sign on the door.
- 6. Hospitals where healthcare provider(s) has admitting privileges.

## **Group Practice Risk Profile**

This risk profile should ascertain the level of the group's involvement and commitment in their effort to provide risk management. It is the Company's philosophy that the greater effort clinics use to reduce risk, the more awareness they have of methods to limit the exposure to malpractice litigation. If properly instituted, a good risk management program will:

- 1. Reduce the risk of malpractice claims by the recognition and elimination of problem areas:
- 2. Augment a defensible position;
- 3. Increase awareness of potential areas of risk;
- 4. Improve the standard of care;
- 5. Provide a mechanism for patient advocacy.

## **Group Practice Claims History Evaluation**

This evaluation ascertains the level of the group's prior claims and loss history and to obtain the appropriate claim information and assess the liability, if any, of a healthcare provider. To make the assessment, identify the following factors:

- 1. Did the healthcare provider depart from the accepted standard of care? Did that departure result in injury, loss, or damage to the patient?
- 2. What was the opinion of the peer review committee, if any, or experts who reviewed the case as to the standard of care rendered?
- 3. Are there any patterns or trends noted in the healthcare provider's practice which could give rise to subsequent professional incidents, such as the same surgical procedure improperly performed, inadequate patient histories or workups, lack of informed consent, improper record keeping and documentation, etc.?
- 4. Assess the number of claims which have occurred from inception of the healthcare provider's practice. Evaluate those that have occurred against the nature of the insured's specialty.
- 5. If a renewal, review the claim representative's case summary, trial review or other evaluation report for their assessment of the merits of the case. Often the Litigation Specialist is in contact with the healthcare provider and is the most knowledgeable of the facts in the case. Did the healthcare provider cooperate with the Litigation Specialist and the Company in preparing the defense?

Upon evaluation of these factors, either a decision or a recommendation for coverage will be formed by the Underwriter.

## **Non-Group Primary Evaluation Criteria**

- 1. Length of time healthcare provider(s) has practiced;
- 2. Stability of practice;
- 3. Reputation and standing within the community served;
- 4. Hospitals where healthcare provider(s) has admitting privileges;

## **Non-Group Risk Profile**

This risk profile should ascertain the level of the healthcare provider's involvement and commitment in their effort to provide risk management. It is the Company's philosophy that the greater effort healthcare providers use to reduce risk, the more awareness they have of methods to limit the exposure to malpractice litigation. If properly instituted, a good risk management program will:

- 1. Reduce the risk of malpractice claims by the recognition and elimination of problem areas:
- 2. Augment a defensible position;
- 3. Increase awareness of potential areas of risk;
- 4. Improve the standard of care;
- 5. Provide a mechanism for patient advocacy.

The maximum credit or debit is 25 percent for dentists, based on the eligibility, primary evaluation criteria, risk profile and loss ratio evaluation, as described in the rules pages.

3. Section 3, Professional Liability Discounts, is amended by adding the following

<u>Loss Free Discount</u>: If an insured is currently receiving the loss free discount and has been loss free for four years or longer, they are eligible to receive a 2.5% credit.

<u>Risk Management Program Discount</u>: If the insured completes a ProAssurance approved Risk Management seminar, they are eligible to receive a 2.5% credit. The credit will be applied at the insured's next renewal. Attendance at the seminar must be completed prior to the renewal date. This credit is applied at the risk level in a group.

First Aid Coverage – Standard coverage will be offered with a sublimit of \$5,000.

<u>Corporate Coverage</u>: Except for actuarially rated accounts, corporations participating in the program are offered corporate coverage at a reduced rate. See Section 5, Item II, Partnership-Corporation-Professional Association Coverage.

4. Section 4, Professional Liability Discounts, is hereby amended by replacing Item IV, Claims Free Credit Program, with the following:

## V. LOSS FREE DISCOUNT PROGRAM

<u>Loss-Free Credit</u>: Healthcare providers who have not experienced losses may be able to receive premium credits as follows:

# Of Loss-Free Years	Annual <u>Credit</u>	Accumulated <u>Credit</u>
1	5%	5%
2	10%	10%
3	15%	15%

<u>New Business</u>: Dentists who have been loss-free (with no indemnity payments) for the past three years will receive the full premium credit of 15 percent. Dentists who have been loss-free for two years will receive a 10 percent credit, while dentists with one year of loss-free experience will receive a 5 percent credit.

<u>Definition of a Meritorious Claim:</u> If any one claim results in an indemnity payment of more than \$3,000 for dentists or all other healthcare providers, the premium for the healthcare provider will revert to the base level. Otherwise, loss-free credits will continue to apply and accumulate, subject to the maximum available credit, as well as Underwriting review.

<u>If a Loss (As Defined) Occurs After Enrollment Into the Program:</u> In this situation, the rates upon renewal revert back to the 100 percent level until the health care provider has been loss free for a full policy year, at which time credits again begin to accumulate.

5. Section 4, Professional Liability Discounts, is hereby amended by adding the following:

#### V. DENTISTS RISK MANAGEMENT PREMIUM CREDITS

Insured dentists who participate in risk management activities approved by the Company are eligible for the following premium credits.

A. <u>Individual Risk Management Activities</u>: Individual dentist insureds shall receive premium credits as indicated for completion, within the 12 months prior to the effective date of the policy being rated, of the following activities:

Activity

A Company-produced online Loss Prevention seminar.

2.5%

Company-produced Supplemental Online Modules (up to four).

0.5% premium credit for every 30 minutes of online coursework (up to a maximum of 2.0%)

- B. Any risk management credit will be revoked or withheld for any of the following reasons:
  - 1. Failure by an individual insured to certify adherence to risk management guidelines adopted by the Company and in effect at the time of application;
  - 2. Demonstrable evidence which indicates that the insured has been or is practicing in violation of guidelines or underwriting criteria adopted by the Company;
  - 3. Results of an underwriting audit which show serious deficiencies, including but not limited to non-compliance with specialty risk management guidelines; or
  - 4. Evidence of falsification of attendance, credit or completion of risk management activities applied towards a risk management credit.

Information obtained in the process of handling a claim will be used in evaluating an insured with respect to the above condition; however, the filing of a claim or incurring any expense or indemnity on behalf of an insured shall not alone be considered grounds for reducing, revoking or withholding a credit.

6. Section 4, Additional Practice Charges, is amended by adding the following

## VII. Dental Board Examination Coverage

Dental students taking their licensing examinations will be offered occurrence coverage for their exposure while taking a dental licensing board examination. Coverage will be provided at limits of \$1,000,000 per incident, \$3,000,000 aggregate. The policy definition of Professional Health Care Services referred to in the policy is limited to only those services rendered by the insured during a dental board examination.

A \$15 charge per examinee will be charged to cover the exposure for these dental candidates. In addition, if the examinee obtains professional liability coverage with the Company after obtaining his/her license to practice dentistry, the Company will apply this fee as a reduction to the insured's first-year premium. The dentist's first professional policy to insure his/her full-time dental practice must be purchased from the Company in order to receive that \$15 reduction.

#### PCWA-127383456 and IL-DPL-012012-RR

Responses to 9/20/2011 objections as prepared by the Actuarial and Underwriting Departments:

- Q1: Please indicate if your company has a plan for the gathering of statistics or the reporting of statistics to statistical agencies?
- A1: The Independent Statistical Service, Inc. (ISS) is our statistical reporting agency.
- Q2: Pursuant to 50 Ill. Adm. Code 754.10, identification of all changes in all superseding filings, as well as identification of all superseded filings is required. Additionally, we require you certify that nothing else has changed from what was previously filed except for the changes brought to our attention in this filing.
- A2: Here is a summary of the proposed changes:
  - 1. Class plan changes and new classification for dentists performing Botox for cosmetic purposes in their procedures as per actuarial memorandum.
  - 2. Territory plan changes as per actuarial memorandum.
  - 3. The rate level indication was for a 107.3% increase. A 17.5% overall rate impact on our in-force book of business was selected based on discussions with senior management.
  - 4. The minimum premium charge will be \$250 for first-year or second-year coverage and \$500 for any subsequent claims-made years and occurrence coverage.
  - 5. The maximum credit is now 25% and the maximum debit is 25%.
  - 6. The \$1M/\$3M corporate limits charge is increasing from 5% to 10% for groups of 2 9 dentists, 9% for groups of 10 –19 dentists, and 7% for groups of 20 49 dentists. The corporate minimum premium is changing from \$50 to \$100.
  - 7. Separate limits for solo corporations will no longer be available.
  - 8. A 7% credit to accept the Waiver of consent to settle Endorsement.
  - 9. The Legal Expense Endorsement is being replaced with Legal Defense Extended Form. Previously insureds had limits of \$5,000 for Legal Expense, but will now have limits of \$25,000 under Legal Defense. All coverages provided under Legal Expense are replicated in Legal Defense, in addition to coverage for Medicare/Medicaid investigations.
  - 10. As a result of the Legal Defense form covering Medicare/Medicaid investigations, the Medicare/Medicaid Billing Errors & Omissions and Medical Records Confidentiality Endorsement has been eliminated.
  - 11. The Part-Time rules have been modified—dentists who are eligible for the new dentist discount are not eligible to also receive the part-time discount.

- 12. If a risk has exposure in 2 or more territories, the classification and rates from higher rated territory will apply.
- 13. The discount provided to dentists new to practice is changing from 50% the first year and 25% the second year to 60% the first year and 40% the second year. Insureds receiving this credit are subject to the minimum premium filed.
- 14. We are now including specific charges for paramedical and allied health providers
- 15. Standard First Aid Coverage is now being offered with a sublimit of \$5,000.
- 16. Vicarious liability charge is changing from 10% to 30%
- 17. The Schedule Rating Plan has been modified to include additional conditions that affect variability in the hazards faced by dentists.
- 18. The new form uses different language to define key terms in the policy, such as damages, professional incident, professional services and (for claims-made policies only) report, reported and reporting.
- 19. The events for which we offer extended reporting coverage at no additional premium charge, in addition to the death or retirement of the insured professional, have been modified as follows:
  - a. We offer extended reporting coverage at no additional premium charge upon the insured professional's attainment of age 65, provided the insured professional has been continuously insured by a ProAssurance Group company on a claims-made basis for 10 years. The reporting endorsement is offered only upon termination of your coverage with a ProAssurance Group company. This represents a significant new benefit for long-term insureds, allowing the flexibility to practice beyond retirement in situations where insurance is provided by a hospital, volunteer clinic, etc.
  - b. We will continue to offer extended reporting coverage at no additional premium charge upon the insured professional's total disability, but the disability must have occurred and continued at least six months prior to termination of the policy.
- 20. The new form makes clear that no insured shall alter, make any improper amendments to, destroy or dispose of patient records or misrepresent or conceal facts pertinent to any incident, claim or suit, or else coverage will be forfeited.
- 21. Unless otherwise required by law, there is no automatic 15-day period for reporting of claims after expiration of the policy period. The insured professional must purchase a reporting endorsement to report claims and trigger coverage after the policy period has expired.
- 22. The new form contains the following exclusions that did not appear on the prior form (refer to the policy form for the actual language of each exclusion):
  - Liability as an owner, administrator, officer, medical director, etc. of a health care entity, unless the insured was directly involved in the care rendered to the patient.
  - Liability under any workers' compensation, unemployment compensation, disability benefits, or similar law.

- Liability for violations of statutes, ordinance or regulations imposing any fine, penalty or other sanction.
- Liability for billing errors or omissions (limited coverage for defense costs is provided under the Medicare/Medicaid Billing Errors and Omissions – Medical Records Confidentiality Endorsement).
- Liability for matters that fall within the Public Health Service Act or the Federal Tort Claims Act.

Thus, the new form is more restrictive in these areas. The new form also excludes from coverage defense and damages for liability arising out of sexual activity or willful, malicious or criminal conduct.

- 23. The new form has removed the following supplemental benefits: reimbursement of the insured for expenses incurred in assisting the Company in the investigation or defense of a claim and payment of a per diem for attendance at hearings or trials.
- 24. The new form makes clear that we shall not be obligated to appeal any judgment.
- 25. Separate coverage limits for contractual liability will no longer be available.

I certify that nothing else has changed from what was previously filed except for the changes brought to your attention in this filing.

LaQuita Goodwin Compliance Specialist

ProAssurance Wisconsin Insurance Company

Muta B. Goodin



VIA EMAIL: <a href="mailto:rwalling@pinnacleactuaries.com">rwalling@pinnacleactuaries.com</a>

November 3, 2011

Mr. Robert J. Walling, FCAS, MAAA Principal and Consulting Actuary Pinnacle Actuarial Resources, Inc. 2817 Reed Road, Suite 2 Bloomington, IL 61704-8295

RE: Illinois Dentists Professional Liability Rate Filing IL-DPL-012012-RR

Dear Mr. Walling:

Please find following the response to your October 27, 2011 letter.

Pursuant to your request, we have removed the sentence in question on page 12 which I believe should satisfy your concerns.

If you have any further questions or concerns, please contact me at (205) 877-4426 or email me at <u>lgoodwin@proassurance.com</u>.

Sincerely,

LaQuita B. Goodwin Compliance Specialist

Eduta B. Soodiin

Enclosure

cc: Caryn Carmean, Neetha Mamoottile, Gayle Neuman, Illinois Department of Insurance

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Filing Company: ProAssurance Wisconsin Insurance Company State Tracking Number: PCWA-127383456

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## **Superseded Schedule Items**

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

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# PROASSURANCE WISCONSIN INSURANCE COMPANY HEALTH CARE PROFESSIONALS UNDERWRITING RULES AND RATES

# **ILLINOIS MANUAL**

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## **SECTION 1**

**INTRODUCTION** 

#### INTRODUCTION

This manual contains the classifications and rates governing the underwriting of Dentists and Allied Health Professionals' Professional Liability Insurance by ProAssurance Wisconsin Insurance Company, hereinafter referred to as "the Company."

#### I. RATES AND PREMIUM CALCULATIONS

- Rates apply on a per incident and annual aggregate basis. The rates for the premium classifications selected by the Company or any special situations not delineated herein are those described in the Professional Liability State Rates and Exceptions Section of this manual, with a minimum premium being \$500 (\$250 first and second-year claims-made coverage and for Allied Health Professionals). If an individual's practice involves two or more rating territories or rating classifications, the highest rating territory or classification applies. Endorsements adding risks/exposures mid-term will be rated in accordance with the Rates and Rules in effect as of the Subject to Section 2., V, (Rate Adjustments for Changes in endorsement effective date. Exposure) of this manual, Reporting Endorsements will be rated in accordance with the Rates and Rules in effect as of the endorsement effective date. Subject to Section 2, V, (Rate Adjustments for Changes in Exposure) of this manual, endorsements effecting changes on risks/exposures currently insured will be rated using the Rules (e.g., rating classification, limits of liability and rating territory) in effect on the date of the change combined with the rates in effect on the later date of either i) the policy term effective date or ii) risk effective date.
- B. Refer to the Company for: Agents should refer to the Company any risk meeting one of the following criteria: a) Any risk or exposure for which there is no manual rate or applicable classification, or b) Risks developing annualized premium of \$100,000 or more for basic limits for individual (a) rating.
- C. <u>Non-Standard Risks</u>: Individuals rejected for standard coverage by the Company may be individually considered for coverage at an additional premium charge or other applicable coverage conditions and limitations on an individually agreed, consent-to-rate basis.
- D. Whole Dollar Premium Rule: The premiums appearing in the State Rates and Exceptions Section of this manual have been rounded to the nearest whole dollar. This procedure shall also apply to all interim premium adjustments, including endorsements or cancellations. A premium involving \$.50 or over, shall be rounded to the next higher whole dollar.
- E. <u>Net of Commission Rule</u>: In the event an agent chooses to forgo all commission and work on a fee basis, rating may be computed by reducing the base rate by the commission percentage that was otherwise payable.

## II. CANCELLATIONS

Cancellations shall be made only within the parameters established by the State of policy issuance as framed in the Cancellation provisions of the policy including any State-specific endorsement thereto.

- A. By the Company: The earned premium shall be determined on a "pro rata" basis.
- B. <u>By the Insured</u>: The earned premium may be determined on a "short rate" basis if the entire policy is cancelled. Pro-rata calculation shall be used if a portion of the coverages or risks are cancelled but other portions of the policy remains in force. "Short rate" calculation means that total earned premium shall equal actual earned premium as of the date of cancellation plus a short rate penalty equal to ten percent (10%) of unearned premium for the remainder of the policy period.
- C. <u>Removal from the State</u>: Subject to state provisions, the policy may be canceled by the Company after the insured no longer maintains at least 75% of his dental practice within the state of issuance, regardless of whether notice has been given by the insured.

# **SECTION 2**

CLASSIFICATION AND/OR RATING MODIFICATIONS AND PROCEDURES

# **CLASSIFICATION AND/OR RATING MODIFICATIONS AND PROCEDURES**

# I. PART-TIME AND SEMI-RETIRED PROFESSIONALS

The Part-Time Discount is available to dentists:

- A. who have at least 15 years of postgraduate clinical practice experience and are scaling back their practice in anticipation of retirement; or
- B. who practice less than 20 hours per week due to family needs (caring for young children and/or ill or disabled family members); or
- C. who are required to practice on a reduced basis as a result of a physical or medical condition, with the company's approval; or
- D. who practice at least 30 hours per week at a hospital, community health center or other health care facility where medical professional liability insurance is provided by the facility. A certificate of insurance listing the Company as certificate holder must be presented annually for the credit to apply.

Insureds eligible for the New Dentist Discount are not eligible for the Part-Time Discount. Also, dentists employing or supervising paramedicals (as listed in Section V, Item I) are not eligible for the Part-Time Discount.

This discount is intended to more accurately rate the insured who practices his specialty on a limited basis. The available discounts are:

		Average Weekly Practice
<b>TYPE</b>	<u>Class</u>	Hours < 20 hours
Dentist	1A to 5	50%
All other		None

<sup>\*</sup> Dentists whose average weekly practice hours are less than 12 hours will be individually evaluated by the company.

Practice hours are defined as:

- hospital rounds,
- charting and patient planning,
- on call hours involving patient contact, whether direct or by telephone,
- consultation with other dentists, and
- patient visits/consultations.

Practice hours of dentists receiving the Part-Time Discount are subject to random audit by the Company.

#### II. LOCUM TENENS

Coverage for temporary substitute health care providers may be provided through the issuance of an Additional Insured endorsement or the Locum Tenens Endorsement. In states not requiring a separate set of limits for the substitute, the Locum Tenens health care providers will be added to the insured's policy as an additional insured, sharing in the insured health care provider's limits. In states requiring separate limits for each health care provider, a Locum Tenens endorsement will be added to the insured health care provider's policy, providing a separate set of temporary limits to the Locum Tenens. Locum tenens coverage should not exceed a period of 90 days.

To cover the processing and administrative costs involved, a \$50 minimum premium charge per Locum Tenens endorsement may be applied. At underwriter's discretion, the processing charge may be waived. The locum tenens dentist must submit an application for Company approval in advance of the requested effective date of coverage.

#### III. CORPORATE LIABILITY - SHARED LIMIT

Where allowed by law, no charge will be made for entities sharing in the available limits of liability of the insured dentists or other insured organizations, providing each member is insured by the Company and the risk is otherwise acceptable.

# IV. FULL-TIME EQUIVALENT RATING

Rating of certain multi-dentist groups may, at the Company's option, be determined on a full-time equivalent (FTE) unit basis. Under this rating method, policies may be issued to positions with individuals who may fill such positions identified rather than being issued to specific individuals. An FTE rate will be determined based upon the filed and approved rate for a given classification of dentists but will be allocated based upon either the number of average hours of practice for a given specialty or the average number of patient contacts/visits in a 12 month period.

All FTE rated applications shall be referred to the Company.

# V. RATE ADJUSTMENTS FOR CHANGES IN EXPOSURE -- CLAIMS-MADE, RETROACTIVE, AND REPORTING ENDORSEMENT COVERAGE

## A. Claims-Made Coverage

The calculations for changes in exposure are performed by taking the difference between claims-made rates for each period of differing exposures. These calculations are appropriate for changes in practice specialty, changes in rating territory or practice in other states, changes between part-time and full-time practice, and other changes that would affect a calculated rate. Currently approved rates, classification tables and discount or surcharge factors for the appropriate state(s) are used. This method can be generalized by using the following formula to calculate a rate for the upcoming year.

- 1. Rate for current practice, determined using a retroactive date equal to the date that the *current* practice patterns began,
- 2. plus rate for prior practice, determined using a retroactive date equal to the date that the *previous* practice patterns began,
- 3. less rate for prior practice, determined using a retroactive date equal to the date that the *current* practice patterns began.

This method is applied in a similar manner if more than one practice change occurred during the previous four years, and the components are pro-rated if the change occurred at a date other than the policy anniversary date.

For example, if a dentist had practiced general dentistry with cosmetic Botox for many years, then stopped practicing cosmetic Botox and began to practice general dentistry-no surgery only, the appropriate premium for the upcoming policy period would be:

General dentist-No surgery rate for claims-made year one, plus General dentists, Cosmetic Botox rate for claims-made year five, less General dentists, Cosmetic Botox rate for claims-made year one.

This produces a blended rate, reflecting the remaining General dentists, Cosmetic Botox exposure that makes up the majority of the expected reported claims in the upcoming year, plus the initial General dentist-No surgery exposure.

The rate for the second year of gynecology-only practice would be:

General dentist-No surgery rate for claims-made year two, plus General dentists, Cosmetic Botox rate for claims-made year five, less General dentists, Cosmetic Botox rate for claims-made year two.

This adjustment process continues for two more years, until the beginning of the fifth year in the new specialty. At that time, the blended rate would be:

General dentist-No surgery rate for claims-made year five, plus General dentists, Cosmetic Botox rate for claims-made year five, less General dentists, Cosmetic Botox rate for claims-made year five, which is simply equal to the General dentist-No surgery rate for claims-made year five.

Although this method of adjusting rates is designed to accommodate most situations, changes in dental practice often result from increasing or decreasing patient loads, additional dental training, relocation of the practice, gradual reduction in practice nearing retirement and other underwriting factors which affect the risk of loss. As a result, the Company may choose to waive the exposure change adjustment process in specific situations, thereby utilizing the current rating variables without modification. Conversely, a debit under the Scheduled Rating Plan may be applied at the underwriter's discretion, based on more than five years of practice in specialties with long claim emergence patterns.

## B. Prior Acts Coverage

When prior acts coverage is provided, the same method is utilized, as if the insured had been with the Company during the prior acts period. Practice information regarding the prior acts period is obtained from the insurance application.

# C. Reporting Endorsement Coverage

If reporting endorsement coverage is to be rated, the same method is utilized, substituting the reporting endorsement rates for the claims-made rates. For example, a reporting endorsement purchased at the end of the second year of general dentist-no surgery practice in the general dentists, cosmetic Botox example described above would be:

general dentist-no surgery reporting endorsement premium for claims-made year two, plus general dentists, cosmetic Botox reporting endorsement premium for claims-made year five, less general dentists, cosmetic Botox reporting endorsement premium for claims-made year two.

# D. Occurrence Coverage

The calculations for changes in exposure are performed by prorating the rates for the periods of differing exposures. These calculations are appropriate for changes in practice specialty, changes in rating territory or practice in other states, changes between part-time and full-time practice, and other changes that would affect a calculated rate. Currently approved rates, classification tables and discount or surcharge factors for the appropriate state(s) are used.

Although this method of adjusting rates is designed to accommodate most situations, changes in dental practice often result from increasing or decreasing patient loads, additional dental training, relocation of the practice, gradual reduction in practice nearing retirement and other underwriting factors which affect the risk of loss. As a result, the Company may choose to waive the exposure change adjustment process in specific situations, thereby utilizing the current rating variables without modification. Conversely, a debit under the Scheduled Rating Plan may be applied at the underwriter's discretion, based on more than five years of practice in specialties with long claim emergence patterns, such as Pediatrics or Obstetrics.

# VI. REPORTING ENDORSEMENTS (Claims-made only)

# A. Reporting Endorsement Premium Calculation

With respect to calculation of Reporting Endorsement premium, all credits/discounts, with the exception of the New Doctor or Dentist Discount, and all debit/surcharges will apply to Reporting Endorsement premium calculations. With respect to risks or exposures written on a consent-to-rate basis, (a) rated basis or Full-Time Equivalent Rating basis at the time the Reporting Endorsement is issued, Reporting Endorsement premium will be calculated on that same basis. If the policy is terminated during the first year, pro-rate the tail premium. For terminations during the second, third or fourth claims-made policy year, blend the applicable tail factors. The Company may refuse to offer deductible options for premium credit on reporting endorsements in the case of insufficient securitization.

# B. Waiver of Reporting Endorsement Premium

The premium for the reporting endorsement may be waived as provided by the contract in force or at the discretion of the Company.

# SECTION 3 PROFESSIONAL LIABILITY DISCOUNTS

# PROFESSIONAL LIABILITY DISCOUNTS

## I. MAXIMUM CREDIT

Maximum credit available per insured will be limited to 25% except for the following:

- Deductibles/Self-Insured Retentions.
- Risks developing \$100,000 or more annualized premium.

# II. NEW DENTIST DISCOUNT

This discount will apply only to solo practicing dentists who have never been in practice and proceed directly into practice from training, or dentists who fit within that category except for an interim period of employment not to exceed two years. Dentists who would otherwise qualify but who are joining an established group practice insured by the Company where their clinical exposure will not exceed 30 hours per week credited as if they have had one additional year of practice. This discount will also apply only to dentists who proceed directly into practice from training, or dentists who fit within the category except for an interim period of employment not to exceed two years.

Year of Coverage	<b>Annual Premium Discount per Policy</b>
Since Training	<u>Dentists</u>
Year 1	60%
Year 2	40%
Year 3	0%

Note that these discounts do not apply to occurrence or extended reporting endorsement rates.

## III. SCHEDULED RATING PROGRAM

The Company has determined that significant variability exists in the hazards faced by dentists engaged in the practice of dentistry. Exposure conditions vary with respect to:

- 1. Number of years experience in dentistry;
- 2. Number of patient exposures;
- 3. Organization (if any) and size;
- 4. Dental standards review and claims review committees;
- 5. Other risk management practices and procedures;
- 6. Training, accreditation and credentialing;
- 7. Continuing Dental Education activities;
- 8. Professional liability claim experience;
- 9. Record-keeping practices;
- 10. Maintenance and utilization of certain monitoring equipment, diagnostic tests or diagnostic procedures;
- 11. Participation in capitation contracts; and\*
- 12. Insured group maintains differing limits of liability on members.\*
- 13. Services provided at correctional facilities, nursing homes or mobile dental units.

In order to recognize these and other factors affecting a particular practitioner or group practice, the Company proposes to apply a debit or credit to the otherwise applicable rate dependent upon the underwriter's overall evaluation of the risk.

The maximum credit will be 25%; the maximum debit will be 25%.

The Scheduled Rating Plan will apply to individuals as well as groups of two or more dentists as the Company becomes aware of variability in the risk characteristics of the individual or group. At the underwriter's discretion, objective credits otherwise applicable to an insured will not be applied in situations where a scheduled debit is deemed necessary.

\* NOTE: No credit will be given for #11, #12 or #13 above.

## IV. DEDUCTIBLES

Deductibles are available to dentists only and may apply either to indemnity only, to indemnity <u>and</u> allocated loss adjustment expenses (ALAE), or to indemnity and ALAE and supplemental payments. Any discount will apply only to the primary limit premium layer (\$1M/\$3M). Deductibles are subject to approval by the company based on financial statements to be submitted by the insured and financial guarantees as required. The company reserves the right to require acceptable securitization in the amount of the per claim or per incident and/or aggregate deductible amount from any insured covered by a policy to which a deductible is attached.

## A. Individual Deductibles

# Discount as a Percentage of Rate for Applicable Primary Limit

These per incident and aggregate (if any) deductibles apply to each insured separately.

INDEMNITY ONLY  Deductible Per Incident	INDEMNITY AND ALAE <u>Deductible Per Incident</u>
\$ 1,000 2.4% \$ 2,000 4.8% \$ 5,000 8.5% \$10,000 10.9% \$25,000 16.9% \$50,000 21.8% \$75,000 27.8% \$100,000 33.9% \$150,000 41.1% \$250,000 48.4% \$400,000 53.2%	\$ 1,000 3.0% \$ 2,000 6.1% \$ 5,000 10.6% \$10,000 13.6% \$25,000 21.20% \$50,000 27.2% \$75,000 34.8% \$100,000 42.4% \$150,000 51.4% \$250,000 60.5% \$400,000 66.6%
\$500,000 60.5%	\$500,000 75.60%
Per Incident/Aggregate	Per Incident/Aggregate
\$ 1,000/ 3,000 2.2% \$ 2,000/ 6,000 4.4% \$ 5,000/15,000 7.7% \$10,000/30,000 9.9% \$25,000/75,000 15.4% \$50,000/150,000 19.8% \$75,000/225,000 25.3% \$100,000/300,000 30.8% \$150,000/450,000 37.4% \$250,000/750,000 44.0% \$400,000/1,200,000 48.4%	\$ 1,000/ 3,000 2.8% \$ 2,000/ 6,000 5.5% \$ 5,000/15,000 9.6% \$10,000/30,000 12.4% \$25,000/75,000 19.3% \$50,000/150,000 24.8% \$75,000/225,000 31.6% \$100,000/300,000 38.5% \$150,000/450,000 46.8% \$250,000/750,000 55.0% \$250,000/750,000 60.5%
\$500,000/1,500,000 55.0%	\$250,000/750,000 68.8%

For deductible to apply per certificate holder, apply a factor of 1.100 to the appropriate deductible factor. For other deductible amounts selected by policyholders, refer to management for rating.

# B. Group Deductibles

Indemnity Deductible

An optional deductible which limits the amount the entire group will have to pay, if multiple claims are made in a policy year, is available. Under this program, the per incident deductible continues to apply separately to each insured involved in a suit. However, the aggregate deductible applies to all insureds in the group combined thereby reducing the organization's maximum potential liability in a policy year.

When an organization is insured with a separate limit of coverage, the organization is counted when totaling the number of insureds below.

Group aggregate deductible discounts apply to \$1M/\$3M premiums only. The applicable Deductible Discount will not change during the policy term despite changes in the number of insureds, but will be limited by any applicable maximum credit amount.

indemnity Deductible					
Per Incident/Aggregat	e	Number	of Insur	<u>eds</u>	Maximum
(\$000)	<u>2 - 19</u>	<u>20 - 40</u>	<u>41 - 60</u>	<u>61 - 100</u>	Credit
5/15	.073	.066	.055	.044	\$ 12,750
10/30	.096	.089	.076	.061	25,500
25/75	.152	.143	.127	.105	63,750
50/150	.205	.197	.180	.154	127,500
100/300	.300	.293	.277	.252	255,000
250/750	.424	.424	.419	.405	637,500
Indemnity & ALAE					
Deductible					
Per Incident/Aggregat	e	Number	of Insur	<u>eds</u>	Maximum
(\$000)	<u>2 - 19</u>	<u>20 - 40</u>	<u>41 - 60</u>	<u>61 - 100</u>	Credit
5/15	.093	.083	.067	.055	\$ 12,750
10/30	.120	.111	.095	.076	25,500
25/75	.191	.180	.159	.132	63,750
50/150	.256	.246	.224	.193	127,500
100/300	.375	.366	.347	.314	255,000
250/750	.530	.530	.524	.506	637,500

## C. Mandatory Deductibles

The deductible mechanism may be applicable when a policyholder exhibits a pattern of claim frequency that exceeds the average for his/her specialty. In the consideration of a deductible assessment, severity is usually not an issue.

Deductibles may be imposed in amounts from \$1,000 to \$250,000 per claim. There is no corresponding premium discount, and there are no aggregate limits on mandatory deductibles.

An amendatory deductible endorsement will be added to the policy at renewal and will be maintained for no less than one year. The policy will be subject to an annual review thereafter for consideration of a revised sanction.

# V. GENERAL RULES

- A. Discounts will only be applied to qualifying insureds at the initial issuance of such policy or at the next renewal date.
- B. Discounts will apply in the following order:
  - 1. Deductible Discount (primary premium only).
  - 2. All other discounts.
- C. Additional practice charges will be applied to the premium after all discounts have been applied.
- D. Corporate Liability premium will be determined after all discounts and surcharges have been applied.

# **SECTION 4**

ADDITIONAL PRACTICE CHARGES

# ADDITIONAL PRACTICE CHARGES

# I. DENTAL SERVICES PROVIDED IN A STATE OUTSIDE THE STATE OF POLICY ISSUANCE

Insureds engaging in the routine care and treatment of patients outside the state in which the policy is issued may be subject to appropriate surcharge or credit based upon rates consistent with those charged for a like risk in said state.

## II. PARTNERSHIP - CORPORATION - PROFESSIONAL ASSOCIATION COVERAGE

Coverage for partnerships, corporations, or professional associations may be written with a separate limit of liability. The premium charge will be a percentage (selected from the table below) of the sum of each member dentist's net individual premium. The minimum premium charge for this coverage is \$100 for dental. However, this minimum premium may be waived for a specific market or program applying to eligible members of an association. For each member dentist not individually insured by the Company, a premium charge will be made equal to 30% of the appropriate specialty rate if the Company agrees to provide such coverage. In order for the entity to be eligible for coverage under the separate policy, the Company must insure all member dentists, or at least 60% of the dentist members must be insured by the Company and the remaining dentists must be insured by another professional liability program acceptable to the Company.

# of Insureds	\$1M/\$3M Charge	\$500K/\$1.5M	\$250K/\$750K
1	N/A	N/A	N/A
2-5	10.0%	18.0%	23.0%
6 – 9	10.0%	17.0%	21.0%
10 – 19	9.0%	13.0%	17.0%
20 – 49	7.0%	9.0%	13.0%
50 or more	5.0%	7.5%	10.0%

# III. PARTNERSHIP-CORPORATION-PROFESSIONAL ASSOCIATION EXTENDED REPORTING ENDORSEMENT COVERAGE

Partnerships, corporations, or professional associations that purchase a separate limit of liability may be eligible to purchase an Extended Reporting Endorsement upon cancellation of the coverage. The premium charge for the entity extended reporting endorsement will be a percentage of the sum of each member dentist's net individual reporting endorsement premium, based on the number of insureds and the table in Paragraph II, above.

## IV. CLAIMS FREE CREDIT PROGRAM

A dentist will be considered claims free for purposes of this credit program if:

- 1. no loss payment has been made during the Evaluation Period, and
- 2. the total of allocated loss adjustment expense [ALAE] payments made during the Evaluation Period plus any Company established reserves for loss or ALAE does not exceed \$35,000.

Only claims reported during the Evaluation Period shall be included in measuring the payment and reserve criteria stated above. The Evaluation Period is based upon the dentist's rating class as defined in the table below and shall end on the effective date of the policy period to be rated. The Evaluation Period shall begin no earlier than the time when the dentist first begins the practice of dentistry following formal training (residency or a continuous period of residency and fellowship). The Company will review the claims history of each insured or applicant for the purpose of evaluating the applicability of each claim based upon the facts and circumstances of specific claims. Reported incidents that do not involve a demand for damages by a third party will not be included in the evaluation.

Dentist Class Evaluation Period

1A-5 10 Yrs.

The claims free dentist will receive a 3% credit for compliance with the minimum Claims Free Period and will earn an additional 1% credit for each continuous claims free year thereafter up to 15% in total. However, if the dentist has been continuously insured by the Company for 10 or more years, the maximum allowable Claims Free Credit that can be earned will be increased to 20%.

Credits will be applied or removed at policy inception or renewal only. Inclusion of claims history with prior carriers is subject to presentation of information acceptable to the Company. The determination of claims to be included and payment or reserve amounts to be considered will be based upon information available at the time the policy is rated, typically 60 days prior to effective date.

Dentists will be treated as "Class 1" for determination of their Evaluation Period and will be eligible for a maximum Claims Free Credit of 15%, in accordance with the earning schedule above. However, the Claims Free Dentist must have no incurred losses or ALAE (payments or reserves) during the Evaluation Period. Notwithstanding any other provisions of this section, no dentist with 2 or more reported claims will be eligible for a claims free credit without management approval.

# V. LEGAL DEFENSE COVERAGE

The Company offers the Professional Legal Defense Extended Coverage to insured dentists at no charge.

Limits of Liability will be offered as follows:

# of insureds	"Each Covered Inv	vestigation" "Each Policy Period"
1 - 5	\$25,000	\$25,000 X (# of insureds
6 - 10	\$25,000	\$125,000
11 - 20	\$25,000	\$175,000
21 +	\$25,000	\$225,000

The limit of liability for "covered audits" will be \$5,000 per covered insured with a deductible of \$1,000 per audit per insured.

# **SECTION 5**

PHYSICIAN EXTENDER, PARAMEDICAL AND ALLIED HEALTH PROFESSIONAL LIABILITY RATING

# I. PHYSICIAN EXTENDER, PARAMEDICAL, ALLIED HEALTH EMPLOYEE PROFESSIONAL LIABILITY

Professional employees (other than dentists, certified registered nurse anesthetists, nurse practitioners, physicians, physicians' assistants, surgeons, surgeons' assistants, advanced practice nurse prescribers) are automatically included, at no additional charge, as additional insureds under policies issued to their employers. The limits of liability are on a shared basis with the employer.

The following paramedical employees may be individually covered by the Company by payment of an additional premium or covered elsewhere through a program deemed acceptable to the Company with minimum limits of liability equal to or greater than those of the insured employer. Coverage is available on a shared-limits basis or with separate individual limits. To determine the additional premium for the coverage selected, apply the appropriate factor from the premium assigned to dentist Class Code 80211, as specified, for the applicable claims-made year and limits of liability:

(Paramedical employees written on a shared-limits basis will be charged a fourth year claims-made premium regardless of retroactive date and the shared-limits factors stated above will always be applied to a fourth year claims-made premium.)

	(Factors based on 80211)		
Employee	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Physician Assistant (PA)	0.1684	0.765	0.1473
Surgeon's Assistant (SA)	0.1684	0.765	0.1473
Certified Nurse Practitioner (CNP)	0.1684	0.765	0.1473
Advanced Practice Nurse Prescriber (APNP)	0.1684	0.765	0.1473

	(Factors based on 80211)		30211)
Employee	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Certified Nurse Anesthetist (CRNA) – not part of an insured group	N/A	1.540	0.186
CRNA employed by an insured group - separate limits basis	N/A	1.025	0.133
CRNA employed by an insured group – shared limits basis with ratio of CRNAs to anesthesiologists between 2:1 and 4:1	N/A	N/A	N/A
CRNA employed by an insured group – shared limits basis with ratio of CRNAs to anesthesiologists no more than 2:1	N/A	N/A	N/A

**NOTE**: When the limits of liability apply on a shared basis with the dentists of the group, the premium charge for the excess limits for the paramedical employees will be calculated at the level that the majority of dentists carry.

# II. ALLIED HEALTH PROFESSIONAL EMPLOYEES

Certain Allied Health professionals are eligible for separate insurance by the Company at individual limits of liability. The premium charge will be determined by applying the factors below to the appropriate rate for the designated Dentist Class Code in the applicable rating territory.

# **STEP-RATING FACTORS**

First Year	50% of mature premium
Second Year	80% of mature premium
Third Year	100% of mature premium

SPECIALTY	CLASS CODE	\$1M/\$3M
		(Factors based on 80211)
Physician Assistant	80116	0.765
Surgeon Assistant	80116(B)	0.765
Certified Registered Nurse Anesthetist	80960	1.540
Dental Assistant	80207	0.018
Dental Hygienist	80208	0.018

At the discretion of the underwriter, additional insured status may be granted to the non-insured allied health entity for a 10% additional charge. The entity will share in the limits of liability of the insured allied health provider but only for the activities of such provider but only for the activities of such provider.

Mature premiums under \$500 are not eligible for the step-rating factors.

# Reporting Endorsements:

Reporting Endorsements are available to Allied Health Professionals insured under separate policies by application of the factors below.

Prior Year	
Claims-Made	<u>Factors</u>
1	1.00
2	1.25
3+	1.50

# **SECTION 6**

DENTAL PROFESSIONAL LIABILITY SPECIALTY CODES AND DESCRIPTIONS

#### DENTAL SPECIALTY CODES & CLASSIFICATIONS

\*

## **DENTISTS - CLASS 1A**

Applies to dentists who perform dentistry on patients who have been treated with local anesthesia or by inhalation sedation and does not apply to treatment involving any general anesthesia or intravenous or intramuscular agent unless performed in a hospital.

This class does not apply to dentists performing extractions, root canals or other oral surgery or endodontic procedures. This class does not apply to oral surgeons.

## **DENTISTS - CLASS 1**

- Applies to dentists who perform dentistry on patients who have been treated with local anesthesia or by inhalation sedation and does not apply to treatment involving any general anesthesia or intravenous or intramuscular agent unless performed in a hospital. This class does not apply to dentists performing the initial placement of dental implants. This class does not apply to oral surgeons.
- Applies to orthodontists and endodontists who perform dentistry on patients who have been treated with local anesthesia or by inhalation sedation and does not apply to treatment involving any general anesthesia or intravenous or intramuscular agent unless performed in a hospital. This class does not apply to dentists performing the initial placement of dental implants. This class does not apply to oral surgeons.
- Applies to periodontists who perform dentistry on patients who have been treated with local anesthesia or by inhalation sedation and does not apply to treatment involving any general anesthesia or intravenous or intramuscular agent unless performed in a hospital. This class does not apply to dentists performing the initial placement of dental implants. This class does not apply to oral surgeons.

## **DENTISTS - CLASS 2**

- Applies to dentists, endodontists and periodontists as defined for Class 1 but, in addition, permits the initial placement of dental implants.
- Applies to dentists, endodontists and periodontists as defined for Class 1 but, in addition, permits dentistry on patients who have been treated by intravenous or intramuscular sedation in the office, but only if the sedation is administered by a Dental or Medical Anesthetist. If intravenous or intramuscular sedation is performed in a hospital only, Class 1 will apply. This class does not apply to oral surgeons.

## **DENTISTS - CLASS 3**

Applies to dentists as defined for Classes 1 or 2 but, in addition, permits dentistry on patients who have been treated by intravenous or intramuscular sedation in the office, administered by the dentist or a CRNA. If intravenous or intramuscular sedation is performed in a hospital only, Class 1 or 2 will apply, as appropriate. This class does not apply to oral surgeons.

## ORAL SURGERY - CLASS 4

Includes all oral surgeons and also applies to dentists as defined in Classes 1A through 3 who additionally perform dentistry on patients who are being treated with general anesthesia in the office.

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# **DENTISTS - CLASS 5**

Applies to dentists as defined for Classes 1 or 2 but, in addition, permits use of cosmetic Botox on patients who have been treated by intravenous or intramuscular sedation in the office, administered by the dentist or a CRNA. This class does not apply to oral surgeons.

# PARADENTAL EMPLOYEE COVERAGE

Coverage on a shared limits basis is automatically provided for professional employees of the Policyholder or an insured under the policy with no additional charge (e.g., dental assistants, dental hygienists and lab technicians).

While a dental insured's insured paradental employees are automatically covered under the policy, a premium charge for Certified Registered Nurse Anesthetists (CRNAs) will be made as indicated in Section 6, I – Employed Certified Registered Nurse Anesthetist.

# **SECTION 7**

STATE RATES AND EXCEPTIONS – DENTISTS

# I. RATES

# A. Dental Rating Classes – Illinois

The following indicates the specialty classification codes applicable to the rating classes on the following pages:

1A	80213
1	80211
	80214
	80215
2	80211(F)
	80211(G)
3	80209
4	80210
5	80211(I)

# **B.** Dentists Professional Liability Rates

# 1. Claims-Made Rates by Year

Territory 1: Cook, Lake, Monroe, St. Clair and Will counties

	\$100,000 / \$300,000				
Class Code	1	2	3	4	5+
1A	400	565	675	780	890
1	450	660	795	915	1,040
2	450	660	795	915	1,040
3	850	1,365	1,705	1,945	2,180
4	1,915	3,250	4,140	4,680	5,220
5	4,175	7,255	9,305	10,445	11,585
		\$200	,000 / \$600,000		
Class Code	1	2	3	4	5+
1A	420	600	720	835	950
1	480	705	855	985	1,115
2	480	705	855	985	1,115
3	920	1,480	1,860	2,115	2,370
4	2,090	3,555	4,535	5,125	5,715
5	4,575	7,960	10,220	11,470	12,725
		\$500,	000 / \$1,000,000		
Class	1	2	2	4	<b>5</b> .
Code	1		3	4	5+
1A	470	690	835	960	1,090
1	540	815	995	1,145	1,290
2	540	815	995	1,145	1,290
3	1,070	1,755	2,210	2,505	2,805
4	2,485	4,260	5,445	6,145	6,850
5	5,495	9,585	12,315	13,830	15,350
		\$1,000	,000 / \$3,000,000		
Class Code	1	2	3	4	5+
				<u> </u>	
1A	515	770	940	1,080	1,220
1	600	915	1,130	1,295	1,460
2	600	915	1,130	1,295	1,460
3	1,215	2,010	2,540	2,885	3,225
4	2,865	4,935	6,310	7,125	7,935
5	6,370	11,140	14,320	16,090	17,855
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# 1. Claims-Made Rates by Year (cont.)

Territory 2: Remainder of State

	\$100,000 / \$300,000				
Class Code	1	2	3	4	5+
1A 1	350 390	475 550	560 655	655 760	745 865
2 3 4 5	390 700 1,515 3,255	550 1,095 2,540 5,625	655 1,355 3,225 7,200	760 1,550 3,655 8,080	865 1,740 4,080 8,955
3	3,233		,000 / \$600,000	0,000	6,933
Class Code	1	2	3	4	5+
1A 1 2 3	365 410 410 750	505 585 585 1,185	600 700 700 700 1,475	695 810 810 1,680	795 925 925 1,885
4 5	1,650 3,565	2,780 6,165	3,530 7,905	3,995 8,870	4,460 9,835
Cl		\$500,0	000 / \$1,000,000		
Class Code	1	2	3	4	5+
1A 1 2 3 4 5	405 460 460 865 1,955 4,270	570 670 670 1,390 3,320 7,415	685 810 810 1,740 4,230 9,515	795 935 935 1,980 4,780 10,685	900 1,055 1,055 2,225 5,335 11,850
Class	\$1,000,000 / \$3,000,000				
Code	1	2	3	4	5+
1A 1 2 3 4 5	440 505 505 980 2,250 4,945	635 750 750 1,590 3,840 8,615	765 910 910 2,000 4,900 11,060	885 1,050 1,050 2,270 5,535 12,420	1,005 1,185 1,185 2,545 6,170 13,780

# 2. Reporting Endorsement Rates by Year

Territory 1: Cook, Lake, Monroe, St. Clair and Will counties

		\$100,000 / \$300,000					
Class Code	1		2	3	4	5+	
1A 1		573 670	868 1,014	1,026 1,199	1,103 1,289	1,140 1,332	
2		670	1,014	1,199	1,289	1,332	
3		404	2,126	2,514	2,701	2,793	
4		362	5,090	6,019	6,468	6,687	
5	7,	461	11,295	13,358	14,354	14,840	
			\$20	0,000 / \$600,000			
Class Code	1		2	3	4	5+	
1A		612	926	1,095	1,177	1,217	
1		718	1,087	1,286	1,381	1,428	
2 3		718	1,087	1,286	1,381	1,428	
		526	2,311	2,733	2,936	3,036	
4 5		680	5,572	6,589	7,081	7,321	
3	8,	195	12,407	14,672	15,766	16,301	
Class		\$500,000 / \$1,000,000					
Code	1		2	3	4	5+	
1A	702		1,063	1,257	1,351	1,396	
1	831		1,258	1,487	1,598	1,652	
2	831		1,258	1,487	1,598	1,652	
3	1,806		2,735	3,234	3,475	3,593	
4 5	4,411 9,885		6,679 14,966	7,898 17,699	8,487 19,019	8,775 19,663	
		\$1,000,000 / \$3,000,000					
Class Code	1		2	3	4	5+	
1A		786	1,190	1,407	1,512	1,563	
1		940	1,424	1,683	1,809	1,870	
		940	1,424	1,683	1,809	1,870	
2 3		077	3,144	3,718	3,996	4,131	
4		110	7,737	9,149	9,831	10,165	
5	11,	499	17,409	20,587	22,122	22,872	

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# 2. Reporting Endorsement Rates by Year (cont.)

Territory 2: Remainder of State

	\$100,000 / \$300,000				
Class Code	1	2	3	4	5+
1A	480	726	859	923	954
1	557	843	997	1,072	1,108
2	557	843	997	1,072	1,108
3	1,121	1,697	2,006	2,156	2,229
4	2,628	3,978	4,704	5,055	5,226
5	5,767	8,731	10,325	11,095	11,471
		\$200.	,000 / \$600,000		
Class Code	1	2	3	4	5+
1.4			017	007	1.010
1A	512	775	917	985	1,018
1	596	902	1,067	1,146	1,185
2	596	902	1,067	1,146	1,185
3	1,214	1,838	2,173	2,336	2,415
4 5	2,872	4,349	5,142	5,526	5,713
3	6,334	9,589	11,340	12,186	12,599
Class		\$500,000 / \$1,000,000			
Code	1	2	3	4	5+
1A	580	878	1,038	1,115	1,153
1	679	1,029	1,216	1,307	1,351
2	679	1,029	1,216	1,307	1,351
3	1,433	2,169	2,565	2,757	2,850
4	3,436	5,202	6,151	6,610	6,834
5	7,631	11,554	13,663	14,682	15,180
		\$1,000	,000 / \$3,000,000		
Class Code	1	2	3	4	5+
1A	647	980	1,159	1,245	1,287
1	763	1,155	1,366	1,468	1,518
2	763	1,155	1,366	1,468	1,518
3	1,639	2,481	2,934	3,153	3,260
4	3,973	6,016	7,114	7,645	7,904
5	8,874	13,436	15,888	17,073	17,652
5	0,07	13,430	13,000	11,013	17,032

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# 3. Occurrence Rates by Year

Territory 1: Cook, Lake, Monroe, St. Clair and Will counties

Class Code	100/300	200/600	500/1500	1000/3000
1A	1,015	1,090	1,260	1,425
1	1,200	1,295	1,510	1,720
2	1,200	1,295	1,510	1,720
3	2,610	2,845	3,385	3,905
4	6,370	6,980	8,385	9,730
5	14,360	15,770	19,010	22,115

Territory 2: Remainder of State

Class Code	100/300	200/600	500/1500	1000/3000
1A	840	900	1,030	1,160
1	985	1,055	1,225	1,380
2	985	1,055	1,225	1,380
3	2,070	2,250	2,665	3,065
4	4,960	5,430	6,510	7,545
5	11,105	12,190	14,685	17,070

# **4. Excess Limits Premium Factors**

Excess limits premium shall be derived by applying the appropriate factor below to the appropriate primary rate. Excess limits are only offered above underlying limits of \$1,000,000.

\$1M/\$3M Primary

<b>EXCESS</b>	Dentists/
LIMITS	Oral Surgeons
\$1M	0.0480
\$2M	0.0960
\$3M	0.1450
\$4M	0.1935
\$5M	0.2225

These factors are based upon negotiated reinsurance agreements. Deviation from these factors up to 25% based upon negotiated agreements with reinsurers and/or underwriting judgment may apply.

# II. EXCEPTIONS

# A. Policy Issuance

- 1. If the insured elects to accept the Waiver of Consent to Settle Endorsement, Form PRA-HCP-612, a credit of 7% will be applied.
- 2. The Illinois State Law Endorsement must be attached to the policy at the time of issuance.
- 3. Item III, Premium Payments, is hereby added to Section 1, Introduction, as follows:

#### III. PREMIUM PAYMENTS

- 1. Annual Payment Plan The premium must be paid in full prior to the inception date of the policy.
- 2. Semi-Annual Payment Plan -60% of the premium must be paid prior to the policy inception date and one installment of 40% is due six months after inception.
- 3. Quarterly Payment Plan -35% of the premium must be paid prior to the policy inception date, with second and third quarterly payments of 25% each and a final quarterly payment of 15%.
- 4. Nine Payment Plan 20% down and eight consecutive monthly installments of 10% each. This plan requires that the policyholder participate in the Electronic Payment Plan in which premiums are automatically deducted from the policyholder's bank account.

No finance charges or fees apply to these payment plans. The option to pay premium on other than the Annual Payment Plan may be withdrawn by the Company if the insured has failed to make premium payments when due.

#### B. Rules

1. Section 3, Professional Liability Discounts, is amended by adding the following:

# VI. BLENDING CREDIT OR DEBIT

A blending credit is available for those accounts that are rated in one territory, but have a percentage of their practice in another (one or more) territory. This credit is intended to bring the premium in line with the exposure per territory. It is not intended to reduce the premium below that of which they would pay in the outside territory. The Named Insured must provide a complete distribution of their practice. This distribution may include percentages for office and hospital practice along with a further breakdown into territory for each facet. This information must be completed in order to provide an accurate credit.

2. Section 3, Professional Liability Discounts, is amended by adding the following:

## VII. GROUP PRACTICE MODIFICATION PLAN

Credits or debits for groups will be determined annually on the basis of our evaluation of each individual group's risk profile, which assesses such characteristics as changes in maturity, number of healthcare providers, specialty composition, management, employees, patient records, quality assurance, facilities, billing procedures and loss history.

# **Group Practice Eligibility**

- 1. a. For a group of dental healthcare providers, two or more permanently licensed, practicing dentists.
  - b. Other markets are not eligible for group practice (entity) policies or rating, unless specifically addressed in this manual.

- 2. Group must be a corporation, partnership, joint venture, or limited partnership association.
- 3. Primary location where both professional services are rendered and administrative functions (billing, patient records) are undertaken.
- 4. Satellites are acceptable to the extent they are controlled and are practicing as part of the primary location.
- 5. The entity must be organized for the purpose of delivering professional services to patients.

# **Group Practice Primary Evaluation Criteria**

- 1. Length of time entity has operated as a group.
- 2. Degree of specialization within the group.
- 3. Stability of members and locations.
- 4. Reputation and standard within the community served.
- 5. Promotional materials, advertising, sign on the door.
- 6. Hospitals where healthcare provider(s) has admitting privileges.

## **Group Practice Risk Profile**

This risk profile should ascertain the level of the group's involvement and commitment in their effort to provide risk management. It is the Company's philosophy that the greater effort clinics use to reduce risk, the more awareness they have of methods to limit the exposure to malpractice litigation. If properly instituted, a good risk management program will:

- 1. Reduce the risk of malpractice claims by the recognition and elimination of problem areas:
- 2. Augment a defensible position;
- 3. Increase awareness of potential areas of risk;
- 4. Improve the standard of care;
- 5. Provide a mechanism for patient advocacy.

# **Group Practice Claims History Evaluation**

This evaluation ascertains the level of the group's prior claims and loss history and to obtain the appropriate claim information and assess the liability, if any, of a healthcare provider. To make the assessment, identify the following factors:

- 1. Did the healthcare provider depart from the accepted standard of care? Did that departure result in injury, loss, or damage to the patient?
- 2. What was the opinion of the peer review committee, if any, or experts who reviewed the case as to the standard of care rendered?
- 3. Are there any patterns or trends noted in the healthcare provider's practice which could give rise to subsequent professional incidents, such as the same surgical procedure improperly performed, inadequate patient histories or workups, lack of informed consent, improper record keeping and documentation, etc.?
- 4. Assess the number of claims which have occurred from inception of the healthcare provider's practice. Evaluate those that have occurred against the nature of the insured's specialty.
- 5. If a renewal, review the claim representative's case summary, trial review or other evaluation report for their assessment of the merits of the case. Often the Litigation Specialist is in contact with the healthcare provider and is the most knowledgeable of the facts in the case. Did the healthcare provider cooperate with the Litigation Specialist and the Company in preparing the defense?

Upon evaluation of these factors, either a decision or a recommendation for coverage will be formed by the Underwriter.

# **Non-Group Primary Evaluation Criteria**

- 1. Length of time healthcare provider(s) has practiced;
- 2. Stability of practice;
- 3. Reputation and standing within the community served;
- 4. Hospitals where healthcare provider(s) has admitting privileges;

# **Non-Group Risk Profile**

This risk profile should ascertain the level of the healthcare provider's involvement and commitment in their effort to provide risk management. It is the Company's philosophy that the greater effort healthcare providers use to reduce risk, the more awareness they have of methods to limit the exposure to malpractice litigation. If properly instituted, a good risk management program will:

- 1. Reduce the risk of malpractice claims by the recognition and elimination of problem areas:
- 2. Augment a defensible position;
- 3. Increase awareness of potential areas of risk;
- 4. Improve the standard of care;
- 5. Provide a mechanism for patient advocacy.

The maximum credit or debit is 25 percent for dentists, based on the eligibility, primary evaluation criteria, risk profile and loss ratio evaluation, as described in the rules pages.

3. Section 3, Professional Liability Discounts, is amended by adding the following

<u>Loss Free Discount</u>: If an insured is currently receiving the loss free discount and has been loss free for four years or longer, they are eligible to receive a 2.5% credit.

<u>Risk Management Program Discount</u>: If the insured completes a ProAssurance approved Risk Management seminar, they are eligible to receive a 2.5% credit. The credit will be applied at the insured's next renewal. Attendance at the seminar must be completed prior to the renewal date. This credit is applied at the risk level in a group.

First Aid Coverage – Standard coverage will be offered with a sublimit of \$5,000.

<u>Corporate Coverage</u>: Except for actuarially rated accounts, corporations participating in the program are offered corporate coverage at a reduced rate. See Section 5, Item II, Partnership-Corporation-Professional Association Coverage.

4. Section 4, Professional Liability Discounts, is hereby amended by replacing Item IV, Claims Free Credit Program, with the following:

# V. LOSS FREE DISCOUNT PROGRAM

<u>Loss-Free Credit</u>: Healthcare providers who have not experienced losses may be able to receive premium credits as follows:

# Of Loss-Free Years	Annual <u>Credit</u>	Accumulated <u>Credit</u>
1	5%	5%
2	10%	10%
3	15%	15%

<u>New Business</u>: Dentists who have been loss-free (with no indemnity payments) for the past three years will receive the full premium credit of 15 percent. Dentists who have been loss-free for two years will receive a 10 percent credit, while dentists with one year of loss-free experience will receive a 5 percent credit.

<u>Definition of a Meritorious Claim:</u> If any one claim results in an indemnity payment of more than \$3,000 for dentists or all other healthcare providers, the premium for the healthcare provider will revert to the base level. Otherwise, loss-free credits will continue to apply and accumulate, subject to the maximum available credit, as well as Underwriting review.

<u>If a Loss (As Defined) Occurs After Enrollment Into the Program:</u> In this situation, the rates upon renewal revert back to the 100 percent level until the health care provider has been loss free for a full policy year, at which time credits again begin to accumulate.

5. Section 4, Professional Liability Discounts, is hereby amended by adding the following:

## V. DENTISTS RISK MANAGEMENT PREMIUM CREDITS

Insured dentists who participate in risk management activities approved by the Company are eligible for the following premium credits.

A. <u>Individual Risk Management Activities</u>: Individual dentist insureds shall receive premium credits as indicated for completion, within the 12 months prior to the effective date of the policy being rated, of the following activities:

Activity

A Company-produced online Loss Prevention seminar.

2.5%

Company-produced Supplemental Online Modules (up to four).

0.5% premium credit for every 30 minutes of online coursework (up to a maximum of 2.0%)

- B. Any risk management credit will be revoked or withheld for any of the following reasons:
  - 1. Failure by an individual insured to certify adherence to risk management guidelines adopted by the Company and in effect at the time of application;
  - 2. Demonstrable evidence which indicates that the insured has been or is practicing in violation of guidelines or underwriting criteria adopted by the Company;
  - 3. Results of an underwriting audit which show serious deficiencies, including but not limited to non-compliance with specialty risk management guidelines; or
  - 4. Evidence of falsification of attendance, credit or completion of risk management activities applied towards a risk management credit.

Information obtained in the process of handling a claim will be used in evaluating an insured with respect to the above condition; however, the filing of a claim or incurring any expense or indemnity on behalf of an insured shall not alone be considered grounds for reducing, revoking or withholding a credit.

6. Section 4, Additional Practice Charges, is amended by adding the following

# VII. Dental Board Examination Coverage

Dental students taking their licensing examinations will be offered occurrence coverage for their exposure while taking a dental licensing board examination. Coverage will be provided at limits of \$1,000,000 per incident, \$3,000,000 aggregate. The policy definition of Professional Health Care Services referred to in the policy is limited to only those services rendered by the insured during a dental board examination.

A \$15 charge per examinee will be charged to cover the exposure for these dental candidates. In addition, if the examinee obtains professional liability coverage with the Company after obtaining his/her license to practice dentistry, the Company will apply this fee as a reduction to the insured's first-year premium. The dentist's first professional policy to insure his/her full-time dental practice must be purchased from the Company in order to receive that \$15 reduction.